

# Private Credentialing of Health Care Personnel: An Antitrust Perspective†

## Part Two\*

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### ABSTRACT

Having argued in Part One against extensive judicial or regulatory interference with private personnel credentialing in the health care field, this Article now shifts its focus to emphasize the anticompetitive hazards inherent in credentialing as practiced by professional interests. Competitor-sponsored credentialing is shown to be a vital part of a larger cartel strategy to curb competition by standardizing personnel and services and controlling the flow of information to health care consumers. Instead of altering the conclusions reached in Part One, however, Part Two sets forth a new and hitherto unexplored agenda for antitrust enforcement, one that the authors believe will increase the quantity and quality of information available to consumers and offer a fairer competitive environment to individuals and groups disadvantaged by the denial of desirable credentials. The specific targets singled out for antitrust scrutiny are (1) the practice of "grandfathering," by which new candidates for credentials are required to meet tougher requirements than were met by existing credential holders; (2) agreements to standardize educational programs if they go beyond setting and applying accrediting standards and impair the freedom of institutions to decide independently whether to offer unaccredited training; (3) agreements by which independent certifying or accrediting bodies limit the nature or scope of competition among themselves; and (4) mergers and joint ventures in credentialing and accrediting. The legal theory supporting antitrust at-

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† Preparation of this article was supported by Grant No. HS 04089 from the National Center for Health Services Research, U.S. Department of Health and Human Services.

\* Part One of this Article appears in Volume 9, Number 2 of the *AMERICAN JOURNAL OF LAW & MEDICINE*.

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tacks in the latter two categories is strengthened by the apparently original insight that commercial information and opinion are themselves articles of commerce such that agreements and combinations restricting their nature and output can be characterized as restraints of trade. Among the many self-regulatory institutions in the health care field whose operation or sponsorship is called into question by the analysis herein are the leading medical specialty boards, the Liaison Committee on Medical Education, various accrediting and certifying bodies in the allied health occupations, and the Joint Commission on Accreditation of Hospitals.

## V. CREDENTIALING AS A PROFESSIONAL CARTEL STRATEGY

Part One of this Article discusses at length the problem of unfairness and deception in private credentialing of health care personnel and in similar standard-setting and accrediting programs. Its conclusion that courts and regulators should exercise only limited oversight of such programs results in large part from its focus on that aspect of competitor-controlled credentialing programs which serves the important procompetitive purpose of supplying useful information and advice to consumers and other purchasers. That focus is widened in this Part of the Article in order to observe how credentialing systems dominated by organized professional interests in the health care industry have served not only as sources of useful information but also as important components of a larger professional effort to limit competition. Because credentialing can have both procompetitive and anticompetitive features, antitrust analysts are challenged to devise rules that will, on the one hand, preserve credentialing systems as unregulated sources of information and opinion and, on the other hand, prevent professional interests from using credentialing bodies to curb competitive diversity and suppress the flow of information from independent sources.

The first step in the necessary antitrust analysis, largely accomplished in Part One, is to establish that judicial and regulatory efforts to guarantee the quality and utility of the information and advice being provided are both uncalled-for by legal principles and unwise from a policy standpoint. The next step is to show how credentialing can serve and has served the interests of various organized professions.<sup>1</sup> This demonstration is offered to emphasize further that the problems requiring antitrust attention in this

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<sup>1</sup> Organized professions have frequently been characterized as cartels. See, e.g., Horowitz, *The Economic Foundations of Self-Regulation in the Professions*, in *REGULATING THE PROFESSIONS* 3, 9 (R. Blair & S. Rubin eds. 1980). Because the term is pejorative, however, care must be taken not to let it interfere with sound analysis of particular conduct. As the discussion in Part One makes clear, collective action may be precompetitive and lawful even when undertaken for solely private, self-interested purposes.

field do not lie primarily in the substance of the information and opinions offered by profession-sponsored bodies but take other forms instead. The discussion in this section of the Article is thus preliminary to the later demonstration that the antitrust laws can be used to attack certain actions by professional bodies that unduly standardize health care personnel and the provision of medical care, obscure the differences that continue to exist among providers despite such standardization, or generally restrain the flow of information and opinion. The overall concern of Part Two is with protecting the diversity that is both an attractive feature of a dynamic health care marketplace and essential to its successful operation.

The discussion in this section further develops the thesis, introduced in Part One, that the health care marketplace should serve as a forum for airing and testing competing ideas about how health-related services should be defined, packaged, and provided. The ideal market would offer consumers a variety of health care options that differ not just in price and amenities but in more fundamental ways. It should, for example, enable consumers to locate providers who share their particular philosophy about how drugs and other technology should be used or about how aggressively disease should be treated. Choices should be influenced, too, by differing price tags, in order that the strength of consumer preferences for more costly styles of care may be tested. Unfortunately, competition in health services has not focused enough on values, preferences, costs, or alternative ideas about how health needs should be met. Instead, because of the dominance of a single profession-sponsored ideology, health care competition has concentrated primarily on the amenities surrounding the provision of an essentially uniform product. Although the American health care system is certainly the most pluralistic in the world, it still reflects the strong preference of organized professional groups for centralizing decision making on important issues in professional hands.<sup>2</sup> The ultimate purpose of this Article is to show how the antitrust laws can be employed to promote dynamic pluralism and ideological as well as other kinds of competition.<sup>3</sup>

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<sup>2</sup> Most foreign health systems, such as the British National Health Service, are explicitly monolithic. Even where private organizations have a role, pluralism is more apparent than real. See Van Langendonck, *Private Diligence Versus Public Inertia? The Use of Private Sick Funds for Manpower Policy Under National Health Programs in Western Europe*, in NATIONAL INSTITUTES OF HEALTH, CHANGING NATIONAL-SUBNATIONAL RELATIONS IN HEALTH: OPPORTUNITIES AND CONSTRAINTS 159, 168 (1978) ("Clearly, the sick funds can only influence to a very limited extent the standards of care provided by the medical profession."). The U.S. system is also less pluralistic than it seems but now possesses, partly because of the antitrust laws, a potential for evolution and diversity that is unique in the world. See Havighurst, *Decentralizing Decision Making: Private Contract Versus Professional Norms*, in MARKET REFORMS IN HEALTH CARE 22 (J. Meyer, ed. 1983)

<sup>3</sup> Although the antitrust laws establish as national policy that competition and decentralized decision making are to guide the health care industry except as otherwise provided by explicit regulatory legislation, the implications of this policy for consumers' autonomy and

The main focus in the ensuing discussion is on physicians and their collective use of credentialing to standardize health care personnel and to suppress information about the differences that inevitably exist within profession-prescribed categories. Similar standardizing tendencies exist, however, in all health care occupations whose members have organized themselves. Likewise, information-suppressing tactics similar to those of the medical profession are common in other professions whose members market their services directly to consumers. Finally, both of the dominant professions of medicine and dentistry exercise substantial standardizing influences over other health care professions and occupations.

#### A. STANDARDIZING HEALTH CARE PERSONNEL AND SERVICES

If one were content to have health care provided by a single monolithic system, it would follow that manpower needs should be defined in advance and educational programs developed to meet them. The role of individuals in such a system would be to satisfy the system's requirements and to fit themselves into the niches for which they had been prepared. New ideas for improving system performance would be generally encouraged, but their implementation would be subject to veto. There would be no room for entrepreneurial initiative. Overall control of the system and ultimate responsibility for its performance would lie with its overseers, professional or political as the case may be.

The current organization and operation of the health care industry reflect the continued strength of the view that it should function as a single, essentially monopolistic system.<sup>4</sup> Although no formal monopoly exists and

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range of choice are seldom fully appreciated. Sociologist Paul Starr once observed that health care is not "a technical activity like water supply," but is instead "primarily a social activity like education." Starr, *A National Health Program: Organizing Diversity*, HASTINGS CENTER REP., Feb. 1975, at 11. He went on to express some admiration for a decentralized (though not necessarily a free-market) system:

Such a system would transfer important decisions from the federal government to a level at which people might have more direct control and a clearer understanding of the consequences. Various religious groups, for example, hold distinct positions on the use of certain medical procedures or on questions like the desirability of prolonging dying patients' lives. Rather than seek a false social consensus, it may be easier and wiser to allow different groups to reach their own conclusions and bear the consequences themselves. Such questions are likely to become progressively more acute as biomedical technology expands our capacity to maintain life after health and to rearrange genetic and physiological processes previously beyond our reach.

*Id.* at 15. For a recent endorsement of a pluralistic, competitive health care system by a philosopher, see P. MENZEL, *MEDICAL COSTS, MORAL CHOICES: A PHILOSOPHY OF HEALTH CARE ECONOMICS IN AMERICA* (1983).

<sup>4</sup> See discussion *infra* text accompanying notes 76-98. The historical roots of this view have been documented by sociologist Paul Starr, who has observed the medical profession's rise to a position of "cultural authority, economic power, and political influence." P. STARR, *THE*

many of the system's monolithic features have begun to break down, the medical profession still maintains significant control or influence at points where an outbreak of ideological diversity and decentralized decision making would threaten the system's integrity. Because the antitrust laws now deny the profession the full range of formal controls that would be needed to manage the system completely, some diversity inevitably exists and is increasing. Yet, in practice, a high degree of standardization is still maintained, in large measure by virtue of a monopolistic ideology that contemplates that change should come not from independent entrepreneurial activity but from within the system as a matter of professional policy or negotiated consensus. The most intricate and complete mechanism for standardizing system inputs is that governing the training and labeling of personnel produced for service in the system.

Although reliance on central direction to ensure the interchangeability of personnel inputs would be logical in a monopolistic system, such a defense of standardization can be immediately rejected because the monopolistic premise, despite its sanction in tradition, offends the antitrust laws and other public policies. On the other hand, a good argument can be made that some standardization is efficient even in a competitive system. Industrial standards-setting programs lawfully exist for just such a purpose, to allow independent producers or users to coordinate their efforts without amalgamating and thereby depriving society of the benefits of competition.<sup>5</sup> Nevertheless, intra-industry understandings on the range of sizes of nuts and bolts, or light bulbs and lamp sockets, have fewer implications for consumer welfare than agreements that implicitly limit the ways in which personal health care can be provided. Obviously, the policy concern is not whether any standardization should be permitted but whether it may have been carried too far in the health care industry, depriving consumers of options whose availability would be worth more than the marginal efficiency gains from further standardization.<sup>6</sup>

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SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982). See Also J. BERLANT, PROFESSIONAL AND MONOPOLY (1975); E. FRIEDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE (1971); E. FREIDSON, PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE (1970). The profession's long control of its legal, economic, and institutional environment has induced a habitual "guild mentality" that it is the business of antitrust law to break down. Weller, *Antitrust and Health Care: Provider Controlled Health Plans and the Maricopa Decision*, 8 AM. J.L. & MED. 223, 224 (1982). On the specific mechanisms of professional dominance, see *infra* text accompanying notes 87-98. Even where the profession does not exercise actual control of the decision making apparatus, its norms and standards are widely respected and tend to limit the scope of innovation. See generally Havighurst, *supra* note 2.

<sup>5</sup> See Part One, nn. 6-8 and accompanying text.

<sup>6</sup> Legally, the concern is whether standardization is achieved by agreement not to produce nonstandard items. Naked agreements not to depart from standards are unlawful and are fundamentally distinguishable from collective promulgation of standards, voluntary compliance therewith, and certification of such compliance. See *infra* notes 128-33 and accompanying text. Of course, participants in an organized health plan such as an HMO may agree to

Although it can be argued that unlimited proliferation of health care options would endanger ignorant consumers and raise the cost of searching the market, there is good reason to believe that standardization has prevented desirable competition.<sup>7</sup> Many options potentially attractive to rational health care consumers have been effectively foreclosed by professional bodies exercising formal and informal powers over educational and other institutions and over individual providers. Although consumers can choose among a large number of competing practitioners, the medical profession has sought to confine consumers, as much as possible, to choosing among things which in the most crucial respects do not significantly differ. Thus, the consumer's "free choice of physician," so jealously guarded by professional interests through the years,<sup>8</sup> has implied very limited freedom to choose anything but a physician. Moreover, aside from

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standards because their joint venture, if not so large as to threaten competition, is procompetitive. Another exceptional situation is presented in *Vest v. Waring*, 1983 Trade Cas. (CCH) ¶ 65,419 (N.D. Ga. 1983), where a powerful organization of ophthalmologists declared it unethical to perform a new surgical procedure outside the framework of a major research study being mounted to determine whether the procedure was safe and efficacious. The formation of such a joint venture to conduct a scientific study is defensible on efficiency grounds, and the profession-wide agreement to cooperate with the study seems reasonably ancillary to the goal of bringing as many procedures as possible within it. The case is a difficult one, however, because the social value of the research depends upon the inability of consumers choosing in a free market to distinguish efficacious procedures from worthless ones. See, e.g., A. COCHRANE, *EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES* (1972). Only judicial notice of such a market failure would justify agreements among physicians to limit performance of the procedure until evidence was collected to establish its value. Of course, the study should be designed as unrestrictively as feasible, so that participation in it is open to all qualified ophthalmologists.

<sup>7</sup> The policy arguments for and against occupational licensure raise similar questions: "[T]he prohibitive cost of information makes it impossible for consumers to distinguish competent from incompetent sellers of certain professional services. Regulation prohibiting the sale of such specified minimal standards of expertise is thought to protect consumers from incompetence and fraud." Martin, *Will the Sun Set on Occupational Licensure?*, in *OCCUPATIONAL LICENSURE AND REGULATION* 142-43 (S. Rottenberg ed. 1980). See also Wolfson, *et al.*, *Regulating the Professions: A Theoretical Framework*, in *id.* at 180, 190 n.8 (citing many of the most important works); Part One, nn. 63-73 and accompanying text. For licensure to be both equitable and efficient, the savings it achieves—in search costs (though searching is still advisable) and by preventing mistaken choices—must exceed the consumer surplus lost due to price increases, including any losses due to decisions to forgo treatment. Much depends, therefore, on the political system's ability to choose the right minimum standard. There is recent evidence that public licensure has not provided the theoretically expected benefits. See generally, *OCCUPATIONAL LICENSURE AND REGULATION* (especially Rottenberg, *Introduction* at 8-9, summarizing the conclusions of the literature). Presumably, private regulation by affected interests would be even less likely to strike the optimal balance between quality and cost considerations and to prevent providers from unduly appropriating consumer surplus.

<sup>8</sup> "Free choice of a physician is the right of every individual." JUDICIAL COUNCIL, AMA, *CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMA* 1981, 29 (1981). See also Olson, *Introduction*, in *A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE* 643 (M. Olson ed. 1981).

osteopaths and a few foreign medical graduates who have leaked into the system, the options available to consumers exercising free choice of physician have included only the relatively homogeneous products of a controlled education process. Other professions, when they have had the opportunity, have also tried to keep practitioners and their services as homogeneous as possible, thus limiting the actual range of consumer choice.

The competition that is frustrated by professional control of the types of personnel employed in the system, rather than being narrowly economic, is heavily value-oriented, even ideological. The significance of the lack of such competition in the health care field received some attention in 1977 when the FTC challenged recognition by the U.S. Commissioner of Education of the AMA-dominated Liaison Committee on Medical Education (LCME) as an acceptable accreditor of medical schools. Although the FTC had expressed concern only about possible use of the LCME to curtail the supply of physicians,<sup>9</sup> one of the authors of this Article submitted a statement raising a more fundamental issue concerning the degree of diversity allowable in educational programs operating under LCME oversight. Specifically, it was alleged that "the LCME, by reason of its control by organized medicine and the medical education establishment, imposes on medical education a particular professional ideology, deeply rooted in a particular perception of the physicians's role in society and antagonistic to educational endeavors premised on different perceptions."<sup>10</sup> This argument was supported by suggestive illustrations of how the educational system subtly shapes such important aspects of medical practice as the balance between scientific and clinical skills, the relative emphasis on primary and acute care, and physicians' tolerance for and skill in economizing. By limiting educational diversity, professional interests in medicine, as in other professional fields, successfully prevented the emergence of different traditions and of different types of professionals who might have served the consumer better.<sup>11</sup>

The ideology dominating the education of health professionals also pervades the closely related field of personnel credentialing. As a result of

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<sup>9</sup> See Letter from Daniel C. Schwartz, Acting Director, Bureau of Competition, FTC, to Edward Aguirre, U.S. Commissioner of Education (Nov. 11, 1976); Statement of Daniel C. Schwartz before the Advisory Committee on Accreditation and Institutional Eligibility, U.S. Office of Education (March 24, 1977). The FTC challenge was not based on antitrust principles but on the Commissioner's own criteria. For a theoretical antitrust challenge to the LCME that seems poorly conceived in light of the analysis in Part One, see Note, *Restrictive Practices in Accreditation of Medical Schools: An Antitrust Analysis*, 51 S. CAL. L. REV. 657 (1978). Discussion *infra* text accompanying notes 165-70 suggests an entirely different antitrust theory for attacking the LCME, however—one that reflects (as the student author's theory does not) the concerns developed in the text.

<sup>10</sup> Letter from Clark C. Havighurst and Gaylord C. Cummins to Ernest C. Boyer, U.S. Commissioner of Education (Designate) (March 9, 1977).

the monolithic structure of specialty certification in medicine, aspirants strive to fit themselves into profession-prescribed molds. Similarly, the credentialing of allied health personnel ensures that the educational needs being met are those defined by the system's professional overseers. In both medical and allied fields, credentialing discourages the emergence of practitioners whose ideas or capabilities differ significantly from the commonplace. Control of market forces influencing manpower design is thus virtually complete: At the same time that certification systems are ensuring that there is little demand for alternative varieties of training, educational accrediting schemes are controlling the supply side of the education market, discouraging the emergence of possibly attractive educational alternatives.<sup>12</sup>

The absence of diversity in education and other credentialing programs has consequences that are difficult to see in the day-to-day world. Nevertheless, there is good reason to believe that society would benefit if the system permitted more than a narrow range of responses to such difficult but socially significant questions as: Must a physician be a competent scientist or only a competent clinician?<sup>13</sup> What types of specialized

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<sup>11</sup> After the famous Flexner Report in 1910, a new accreditation program, largely borrowed from Johns Hopkins University, rigidly standardized medical education and gave it a heavily academic emphasis that remained in place for at least a generation. See R. STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* 66-73 (1971); Kessel, *Higher Education and the Nation's Health: A Review of the Carnegie Commission Report on Medical Education*, 15 J.L. & ECON. 115 (1972); Kessel, *The AMA and the Supply of Physicians*, 35 LAW & CONTEMP. PROBS. 267 (1970). Much greater educational variety appears today, but the range of innovation may still be excessively narrow. See generally I. LEWIS & C. SHEPS, *THE SICK CITADEL: THE AMERICAN ACADEMIC MEDICAL CENTER AND THE PUBLIC INTEREST* (1983); P. FELDSTEIN, *HEALTH CARE ECONOMICS*, ch. 15 (1979); Wallis, *Med School, Heal Thyself*, TIME, May 23, 1983, p.54. See also *infra* notes 13, 17-20; Petersdorf, *The Doctors' Dilemma*, 299 NEW ENG. J. MED. 628 (1978), and Perkoff, *General Internal Medicine, Family Practice, or Something Better?*, 299 NEW ENG. J. MED. 654 (1978). The latter two references discuss the strong standardizing influence of academic medical center training on students of internal medicine.

<sup>12</sup> "Generally, directors of graduate programs are aware of the need to provide an educational program that will effectively prepare graduates of their programs to become certified in a specialty. Resident physicians recognize the importance of certification by the boards and are aware of the pressures to meet the requirements of the boards satisfactorily." AMA, *82nd Annual Report on Medical Education in the U.S.*, 248 J. A.M.A. 3225, 3233 (1982).

<sup>13</sup> Debate over the proper balance between scientific and clinical training was an important aspect of the early struggles between generalism and specialism in medicine. See R. STEVENS, *supra* note 11, at 43-44, 115-16. Proposals to create an alternative type of physician with less scientific training, see, e.g., McDermott, *General Medical Care: Identification and Analysis of Alternative Approaches*, 135 JOHNS HOPKINS MED. J. 292, 313 (Nov. 1974), have been poorly received by the education establishment. See, e.g., W. ANLYAN, *et al.*, *THE FUTURE OF MEDICAL EDUCATION*, ch. 10 (1973). Such proposals are threatening to professional solidarity and inconsistent with the prevalent view that there is one right way to train physicians, which must be discovered and implemented by the system. For an illustration of this view, see Eichna, *A Medical-School Curriculum for the 1980's*, 308 NEW ENG. J. MED. 18 (1983), and Correspondence, 308 NEW ENG. J. MED. 1230 (1983).



personnel, both physician and nonphysician, can best serve consumers?<sup>14</sup> What training, inside or outside the classroom, best equips personnel of various types for clinical practice?<sup>15</sup> What relationships among different health professionals should exist and be inculcated through professional training and the certification process?<sup>16</sup> Can computers or paraprofessionals now do many of the things that physicians are relied upon to do?<sup>17</sup> What assumptions about the locus, organization, and financing of professional practice should underlie educational requirements and certification standards?<sup>18</sup> Should aspirants be rated higher or lower for making economizing choices? Which economizing choices are permissible?<sup>19</sup>

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<sup>14</sup> Under a regulatory or manpower planning approach, manpower needs are assessed prospectively on the basis of estimates of technological and demographic developments, and educational resources are mobilized to turn out the needed products. In a system based on decentralized decision making, private estimates by educators supplying and students demanding training guide the system and are constantly subject to reexamination; good estimates of future supply and demand conditions are rewarded and poor ones punished. Strong sentiment for manpower planning appeared in the work of the Graduate Medical Education National Advisory Committee (GMENAC), discussed *infra* note 20. See also Comanor, *Health Manpower and Government Planning*, 5 REG. 47 (May/June 1981). Although the system currently lacks direct control over educational pipelines and the federal government has only limited tools, mostly subsidies, at its disposal, accrediting and credentialing practices facilitate standardization of personnel types and can exert some influence over supply by raising training costs and limiting training opportunities.

<sup>15</sup> See *supra* note 11. Consistent with the preference for standardization, specialty certification requirements reveal a preference for academic over practical training, the latter being gradually phased out as an entry pathway in each specialty over time. See Part One, n. 35. A good example is the newly approved American Board of Emergency Medicine, whose "practice category" for examination eligibility will expire in 1988, after which time all candidates must be trained in approved residency programs. See AMERICAN BOARD OF EMERGENCY MEDICINE, POLICIES AND PROCEDURES 5-6 (1982). The same trend toward academicization and standardization of training is visible in nonphysician health professions as well. See Part One, n. 51 and accompanying text.

<sup>16</sup> For discussion of the relationships between physicians and nonphysician health professionals, see *infra* notes 163-64 and accompanying text.

<sup>17</sup> Expansion of the roles of paraprofessionals, especially those of "physician extenders," reduces the realm of physicians' exclusive competence and may threaten them with loss of their gate-keeping function. See, e.g., Harrell, *Are Doctors Necessary for Primary Care?*, 53 J. MED. ED. 365 (1978) (proposal that physicians leave all primary care to nonphysician practitioners and act only as specialists, consultants, and referees). On emerging uses for computers, see, e.g., Miller *et al.*, *INTERNIST-I, An Experimental Computer-Based Diagnostic Consultant for General Internal Medicine*, 307 NEW ENG. J. MED. 468 (1982); Barnett, *The Computer and Clinical Judgment*, 307 NEW ENG. J. MED. 493 (1982).

<sup>18</sup> Medical educators have been criticized for overemphasizing hospital-based acute care and inadequately preparing physicians to provide primary care. See, e.g., ALPERT & CHARNEY, *THE EDUCATION OF PHYSICIANS FOR PRIMARY CARE* (DHEW Pub. No. HRA 74-3113, 1973). In addition, no medical school is known to have undertaken the training of physicians specifically for practice in health maintenance organizations or other innovative settings. An HMO once reported that residency programs in its hospitals were forced by accreditation requirements to be "rather traditional." Shearn, *Professional Education in a Service System*, in *THE KAISER PERMANENTE MEDICAL CARE PROGRAM* 123 (A. Somers ed. 1971).

<sup>19</sup> Medical education is frequently blamed for promulgating, and certainly is responsible for reinforcing, the widely noted cost-is-no-object ideology that came to pervade medical care

Strong and often conflicting views on questions such as these are held within the health care establishment. Typically, the widest divisions exist between physicians and nonphysicians and between practitioners and educators. Such differences of opinion are most often resolved, however, through internal debate and negotiation rather than in the marketplace.<sup>20</sup> Because relatively few of the innumerable issues of how care should be organized and by what means it should be delivered are ever submitted to the judgment of consumers (or independent entities competing for consumer favor), opportunities for breaking down the dominant ideology have been limited. Although medical institutions are constantly accommodating their policies to internal pressures and external threats, centralized decision making remains the professional norm. The educational and other issues at stake in personnel credentialing are just a few of the innumerable controversial issues that the medical profession has sought to reserve for resolution within the "house of medicine."<sup>21</sup> The profession's ideological monopoly, though not complete, has been remarkably successful in standardizing educational programs, personnel, and the range of options available to health care consumers.

It is difficult to sum up precisely what the medical profession has sought to gain from its efforts to standardize medical care. The conventional view is, of course, that economic gain was not the object at all, and certainly the effort expended by many dedicated physicians in credential-

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in the age of insurance. See V. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS AND SOCIAL CHOICE 59-60, 145 (1974). This ideology strengthened and was used to justify professional resistance to cost containment. See Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 20-30 (1975); see also *infra* text accompanying notes 97-99. On the clash between the dominant ideology and economizing HMOs, see *supra* note 18; Havighurst & Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?*, 1975 UTAH L. REV. 381, 401-06.

<sup>20</sup> A currently prominent issue demonstrating the widespread preference for centralized over decentralized (market) decision making is the future supply of health manpower, a matter of great interest to both practitioners and educators. In the 1960s, a perceived shortage of physicians and other personnel led to governmental subsidies aimed at expanding supply. In the 1970s, warnings of an impending excess of physicians were heard, and the Graduate Medical Education National Advisory Committee (GMENAC) undertook to determine the proper numbers for each specialty and the proper balance of physicians and nonphysicians. GMENAC, SUMMARY REPORT TO THE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES (1980). Many discussions of the GMENAC report call for a consensus among health care decision makers to act upon its findings. E.g., Ginzberg *et al.*, *The Expanding Physician Supply and Health Policy: The Clouded Outlook*, 59 MILBANK MEM. FUND Q. 508 (1981); Tarlov, *Shattuck Lecture—The Increasing Supply of Physicians, the Changing Structure of the Health-Services System, and the Future Practice of Medicine*, 308 NEW ENG. J. MED. 1235 (1983); Lewis, *AAMC Head Urges Tighter Accreditation to Limit MD Supply*, AM. MED. NEWS (Nov. 26, 1982). For a voice calling for reliance on market forces to determine supply, see Comanor, *supra* note 14. Interestingly, the AMA also takes a laissez-faire position. See AMA, *78th Annual Report on Medical Education in the U.S.*, 240 J. A.M.A. 2810, 2811 (1978).

<sup>21</sup> This expression appears in revealing quotations from medical society documents in FTC, STAFF REPORT AND PROPOSED REGULATION RULE, MEDICAL PARTICIPATION IN CONTROL OF BLUE SHIELD AND CERTAIN OTHER OPEN-PANEL MEDICAL PREPAYMENT PLANS 160-61 (1979).

ing and accrediting activities has been inspired not by narrow self-interest but by a sense of professional responsibility, a sincere desire to ensure high professional standards.<sup>22</sup> Nevertheless, it is hard to believe that the profession as a whole tolerated and supported the efforts of these disinterested few without some expectation of economic benefit. Thus, an alternative explanation of the profession's standardization efforts is that intraprofessional differences had to be minimized and the remaining conflicts internally reconciled in order to maintain that professional solidarity which was essential to effective political action and to continued public acceptance of professional bodies as arbiters of issues affecting physicians' economic welfare.<sup>23</sup>

It is also possible, however, to detect some closer parallels between the medical profession's policies and the activities of more typical cartels. In other industries, product standardization has frequently been an essential feature of price-fixing conspiracies, which are virtually impossible to maintain unless products are homogeneous.<sup>24</sup> Although it might seem that the medical profession could not reasonably hope to eliminate all qualitative and other differences among physicians or to suppress information about them to an extent sufficient to ensure successful price fixing, several factors suggest that professional cartelization efforts may not have been entirely in vain. The profession is tightly organized in many local markets, features a high degree of social and professional solidarity, and has carefully cultivated ethical constraints on competitive behavior. In addition, referral patterns, hospital staff privileges, and other institutional factors create a high degree of interdependence among established practitioners and make new entrants unusually dependent upon the good will of their competitors.<sup>25</sup> Most importantly, there may be only a small number of specialists of a particular type in a particular local market, and those few

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<sup>22</sup> Unfortunately, the individual physicians who are most vulnerable to antitrust suits include many who have selflessly accepted responsibility for improving the profession's overall performance. The problem lies, of course, not in their motives but in the monopolistic premise underlying their efforts. Society, disappointed by the health care industry's inability to control its own costs, is surely justified in insisting, through application of the antitrust laws, on a new set of ground rules to govern professional activities.

<sup>23</sup> Discussion *infra* in text accompanying notes 54-58 shows how standardization of specialties served these goals. The references cited *supra* note 4 demonstrate the extent to which professional sovereignty and solidarity had to be carefully nurtured.

<sup>24</sup> See, e.g., *C-O-Two Fire Equip. Co. v. United States*, 197 F.2d 489, 493 (9th Cir. 1952); *Milk & Ice Cream Can Inst. v. FTC*, 152 F.2d 478, 482 (7th Cir. 1946); F. SCHERER, *INDUSTRIAL MARKET STRUCTURE AND ECONOMIC PERFORMANCE* 200-05 (2nd ed. 1980). In *FTC v. Cement Inst.*, 333 U.S. 683, 715 (1948), there was evidence that the defendant price-fixers "had, in the interest of eliminating competition, suppressed information as to the variations in quality that sometimes exist in different cements."

<sup>25</sup> For an analysis emphasizing interdependence in the dental services market, see Lipscomb, *A Political Economic Theory of the Dental Care Market*, 72 AM. J. PUB. HEALTH 665 (1982).

may be organized into a still smaller number of single-specialty group practices. Given the many circumstances conducive to cartel behavior, the homogenization of specialists and compartmentalization of practice that result from specialty certification could readily facilitate explicit or tacit collusion.<sup>26</sup>

Another feature of the medical marketplace that substantially increases the probable payoff to physicians from standardizing professional personnel and services is the dominant role of third parties in paying for care. Because these payers do not experience any of the nonprice variations in the quality and character of the medical services for which they pay, they are much more easily persuaded than patients would be that physician services are fungible. Moreover, government and private third-party payers can anticipate both administrative inconvenience and resistance from providers and consumers if they attempt to differentiate among professionals for payment purposes.<sup>27</sup> For these reasons, most third parties have been satisfied to ignore all but profession-recognized differences among physicians.<sup>28</sup> A corollary of this policy has been acceptance of the general notion that there is a maximum "reasonable" fee, perhaps higher for recognized specialists, for each particular physician service.<sup>29</sup> Without a high degree of standardization, it is doubtful that third parties could have been prevented from bargaining with individual physicians and discriminating among them on the basis of price.<sup>30</sup> As it turns out, however,

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<sup>26</sup> Antitrust doctrine recognizes that certain concerted actions that do not themselves eliminate competition and certain consciously parallel conduct may be unlawful because they strengthen oligopolistic interdependence or otherwise facilitate oligopolistic behavior. *E.g.*, *United States v. Container Corp.*, 393 U.S. 333 (1969) (exchange of price information); *Boise Cascade Corp. v. FTC*, 637 F.2d 573 (9th Cir. 1980) (delivered pricing; proof of collusion or actual effect held lacking); *In re Ethyl Corp.*, [1979-83 Transfer Binder] TRADE REG. REP. (CCH) ¶ 22,003 (1983) (final order) (price "signalling," "most-favored-nation" clauses). On standardization as a facilitating mechanism, see references *supra* note 24.

<sup>27</sup> See generally Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303.

<sup>28</sup> For a case holding that the Medicare law prohibits recognition even of board certification as a basis for higher reimbursements, see *Michigan Academy of Family Physicians v. Blue Cross and Blue Shield*, 502 F. Supp. 751 (E.D. Mich. 1980).

<sup>29</sup> Accepting this basic premise, third-party payers have generally committed themselves to reimburse patients for their doctor bills up to some maximum amount per service derived by reference to prevailing fee levels. The most widely used reimbursement method—that of paying "usual, customary, and reasonable" fees—is ultimately based upon the assumption that most physicians, whose charges for insured services are subject to little competitive pressure, are ethical practitioners and therefore do not abuse their discretion. The implausibility of the assumption that pricing should be a matter of ethics or value of service, not competition, is a fair measure of the success of the medical cartel in having its way with those who spend consumers' and taxpayers' money for medical care. See generally Havighurst & Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, 4 J. HEALTH POL., POL'Y & L. 48 (1979).

<sup>30</sup> A recent trend toward the development of so-called "preferred provider organizations" (PPOs) is finally beginning to show what is possible. Organized by insurers and others, PPOs sharply distinguish among physicians on the basis of price and create incentives for patients to

third-party payers are almost totally unequipped to cope with even the most obvious differences among providers when they surface in a reimbursement context.<sup>31</sup> The resulting lack of price competition among providers is perhaps the most serious inefficiency built into typical third-party reimbursement systems because of the activities of the medical cartel.<sup>32</sup>

The argument herein that standardization of health care personnel has unduly narrowed the range of options available to consumers and served the interests of physicians and other organized professional groups is not meant to discredit accreditation and certification efforts as such, even though these are the mechanisms by which standardization has been achieved. Nevertheless, standardization can be carried too far, and credentialing and accrediting systems should not be applauded without considering whether their effects are more anticompetitive than procompetitive and efficiency-producing. Before presenting a framework for answering this question in an antitrust context, the extensive control exercised by professional organizations over the availability to consumers of information about professionals must be noted. It will appear that the medical profession's extensive efforts to standardize physicians had to be supplemented by efforts to suppress information concerning those differences

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patronize lower-cost practitioners. See, e.g., Cassidy, *Will the PPO Movement Freeze You Out?*, MED. ECON., Apr. 18, 1983, at 262; *Preferred Provider Organizations: A New Concept in Health Care*, FED. AM. HOSP. REV., July/Aug. 1982. Qualitative and efficiency-related distinctions are harder to draw but are a natural next step. Although the antitrust laws are thought by many to inhibit selectivity by insurers and large medical groups, recent cases involving prescription drug plans suggest that these problems are minimal. See, e.g., *Feldman v. Health Care Serv. Corp.*, 1982-83 Trade Cas. (CCH) ¶ 65,042 (N.D. Ill. 1982); *Medical Arts Pharmacy v. Blue Cross and Blue Shield*, 518 F. Supp. 1100 (D. Conn. 1981) *aff'd*, 675 F.2d 502 (2nd Cir. 1982); *Sausalito Pharmacy v. Blue Shield of California*, 1981-1 Trade Cas. (CCH) ¶ 63,885 (N.D. Cal. 1981). These cases confirm the legal status of price agreements between insurers and providers that the Supreme Court left unresolved in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). On the importance of such contracts and selectivity, see Havighurst & Hackbarth, *Private Cost Containment*, 300 NEW ENG. J. MED. 1298 (1979).

<sup>31</sup> Thus, when a service is one that both nonphysicians and physicians can lawfully provide, insurers and government are at a loss to know what to do. Some have sought to maintain the integrity of their reimbursement systems by refusing to pay for the services of such nonphysicians as chiropractors and clinical psychologists, thus occasioning numerous state laws compelling insurance coverage of services provided by various categories of nonphysicians. See *Selected State Statutory Provisions Relating to the Insured's Choice of Provider and to Reimbursement Practices*, STATE HEALTH LEGIS. REP., Feb. 1983, at 7; Wriston, *Nurse Practitioner Reimbursement*, 6 J. HEALTH POL., POL'Y & L. 444 (1981). When coverage is provided, how much to pay nonphysicians has been a problem for the payers, who are administratively comfortable only when they can pretend that all "coded" services are qualitatively alike. See 1 LEWIN & ASSOCS., REPORT TO THE FTC COMPETITION AMONG HEALTH PRACTITIONERS: THE INFLUENCE OF THE MEDICAL PROFESSION ON THE HEALTH MANPOWER MARKET, ch. V (hereinafter cited as LEWIN REPORT); Thompson, *Non-Physician Reimbursement Practices of Third Party Payers*, in AMERICAN SOCIETY OF LAW & MEDICINE, LICENSING AND CREDENTIALING OF HEALTH CARE PROVIDERS (Conf. Proc., October 25-26, 1982). Cf. *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980).

<sup>32</sup> See generally Havighurst, *supra* note 27.

among physicians which could not be completely eradicated but could at least be kept obscure.

## B. CONTROLS ON THE FLOW OF INFORMATION AND OPINION

The medical profession has assumed a strategic position from which to control the flow of information and ideas regarding medical services and the personnel who provide them. As a source of information regarding medical specialists, the profession has been highly selective in what it offers the public, thus suggesting that information is supplied more in order to control its nature and quantity than to aid consumers in shopping in a competitive market. Moreover, the profession has not contented itself simply with publishing its own view of what constitutes a sufficient demonstration of competence in particular fields. It has also attempted to control the form and content of information that its members can publish individually and collectively for consumers' benefit.<sup>33</sup> Indeed, the modicum of disclosure provided by specialty certification has served the profession as an excuse for suppressing news of the additional differences that inevitably exist among practitioners. Not only have consumers thus been denied information concerning options actually available, but restraints on information have served to curtail the development of new options by denying innovators the means of publicizing them. The discussion here again focuses primarily on the actions of physicians, but all independently practiced professions have long sought to limit the availability of information to consumers by curbing their members' advertising and otherwise.<sup>34</sup>

### 1. Restraints on Professional Advertising

A review of the medical profession's long history of ethical inhibitions on physician advertising<sup>35</sup> yields useful insights into professional control of information concerning medical specialties. Although the profession toler-

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<sup>33</sup> See *infra* notes 35-41 and accompanying text.

<sup>34</sup> E.g., *In re RMJ*, 102 S. Ct. 929 (1982) (controls on lawyer advertising); *Friedman v. Rogers*, 440 U.S. 1 (1979) (optometry advertising, prohibition of trade names); *National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679 (1978) (ban on competitive bidding by engineers); *Bates v. State Bar of Ariz.*, 433 U.S. 350 (1977) (ban on lawyer advertising in newspapers); *Semler v. Oregon State Bd. of Dental Examiners*, 294 U.S. 608 (1935) (prohibition of dentist advertising); *Nara v. American Dental Ass'n*, 526 F. Supp. 452 (W.D. Mich., 1981) (controls on dentist advertising, discussed *infra* note 56); *In re American Dental Ass'n*, 94 F.T.C. 403 (1979) (consent order). See Benham & Benham, *Regulation Through the Professions: A Perspective on Information Control*, 18 J.L. & ECON. 421, 446 (1975) ("There is a basic incompatibility between providing consumers with the information which is generated in the usual commercial market and the implementation of professional codes of ethics.").

<sup>35</sup> An extensive treatment of this subject appears in findings by the administrative law judge in *In re AMA*, 94 F.T.C. 701, 812-65 (1978). See also Canby & Gellhorn, *Physician Advertising: The First Amendment and the Sherman Act*, 1978 DUKE L.J. 543.

ated limited advertising of certain basic facts about a physician, it long attempted to draw the line at "solicitation" of patients, which was declared unethical. A somewhat liberalized version of the AMA's guidelines defining solicitation was issued in 1976, shortly after the learned professions were finally declared subject to the Sherman Act by the Supreme Court<sup>36</sup> but not before the FTC had issued a complaint attacking the AMA's restrictive policies. Despite claims that the AMA had mended its ways by issuing the new guidelines, the FTC found past violations and concluded that they had not been cured by the new pronouncement. The FTC's 1979 cease and desist order in the AMA case was upheld by a 2-1 margin in the court of appeals and by a 4-4 vote (without opinion) in the Supreme Court.<sup>37</sup> In its decision, the FTC cited several instances in which physicians were penalized for advertising innovative (nonstandard) services.<sup>38</sup>

The AMA Judicial Council's 1976 opinion regarding solicitation essentially defined it as any effort to persuade or influence patients by misleading them.<sup>39</sup> The FTC and the reviewing courts found the AMA's definition difficult to dispute on its face. Nevertheless, the elasticity of many of the operative terms, the possibility of their selective enforcement to stifle aggressive competitors, and the absence of any evidence (other than the new, lawyer-approved language) that the AMA really intended any change in its historical antipathy to competition led the FTC to issue its order. In its 1980 revision of the Principles of Medical Ethics, the AMA House of Delegates finally deleted all reference to solicitation,<sup>40</sup> but the court of appeals still found that this belated change did not obviate the FTC's action.<sup>41</sup>

Though finding the AMA and local medical societies guilty of Sherman Act violations, the FTC nevertheless left the societies an opportunity to police deceptive advertising in the future, subject to Commission oversight.<sup>42</sup> The FTC expressed no concern that the health care marketplace

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<sup>36</sup> Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

<sup>37</sup> *In re AMA*, 94 F.T.C. 980 (1979), *modified and enforced*, *AMA v. FTC*, 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided Court*, 455 U.S. 676 (1982).

<sup>38</sup> 94 F.T.C. 1005-06; *see also In re AMA*, 94 F.T.C. at 819-36.

<sup>39</sup> The opinion defined prohibited solicitation as statements or claims that

(1) contain testimonials; (2) are intended or likely to create inflated or unjustified expectations of favorable results; (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice; or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

*AMA Clarifies Policy on Advertising by MDs*, AM. MED. NEWS, April 19, 1976, at 9.

<sup>40</sup> *See JUDICIAL COUNCIL*, *supra* note 8, at ix.

<sup>41</sup> *AMA v. FTC*, 638 F.2d at 451.

<sup>42</sup> *In re AMA*, 94 F.T.C. at 1029-31. Although the administrative law judge would have required the AMA to submit any advertising guidelines to direct commission oversight, the

might be less dynamic and the public debate over health care options less comprehensive and robust under a regime in which advertisers must weigh every word or assertion to eliminate the possibility that their competitors might find it deceptive. Indeed, the FTC, as an agency, has tended over the years to be as skeptical as the medical profession about the ability of consumers to judge advertising claims.<sup>43</sup> In addition, it seems likely that at least four Supreme Court justices share this skepticism and would have accepted the AMA's latest guidelines as valid professional self-regulation, aimed at eliminating inappropriate expressions of fact and opinion.<sup>44</sup> Thus, although new antitrust and constitutional protections for professional advertising now exist, they are unlikely to prevent private or public regulators from denying consumers a great deal of important but not readily verifiable information. Instead, the emphasis will be on permitting disclosure of basic, objective facts, such as price, location, and hours of operation—what economists have called “search” information. Professional advertising that features quality claims, asserts opinions, or contains arguable half truths is likely to be rare.

The value of advertising search information to consumers depends upon the extent to which products or services can be adequately described thereby. Almost all necessary information about a familiar or standardized product or service, such as the services of a notary public, can be conveyed as search information, whereas other things, such as a restaurant, cannot be described fully in those terms alone. Although many professional services defy adequate description in terms classifiable as search information, there are some professional fields where search information, particularly price information, can be very important. For example, in the field of optometry,

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order was subsequently modified, first by the Commission and further by the court of appeals, to permit adoption of guidelines prohibiting “representations . . . that respondent reasonably believes would be false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act.” 638 F.2d at 452. The order also permits enforcement of “reasonable ethical guidelines . . . with respect to uninvited, in-person solicitation of actual or potential patients, who, because of their particular circumstances, are vulnerable to undue influence.” 94 F.T.C. at 1037-38. This is all that remains of the solicitation ban. Questions about this order are raised *infra* note 51.

<sup>43</sup> The FTC's paternalism and distrust of advertising has been much discussed. *E.g.*, R. POSNER, REGULATION OF ADVERTISING BY THE FTC (1973); E. KITCH & H. PERLMAN, LEGAL REGULATION OF THE COMPETITIVE PROCESS 177-267 (2d ed., 1979). For reference to FTC Chairman Miller's proposed new and narrower definition of deception and the FTC's proposed relaxation of advertising substantiation requirements, see Part One, n. 197 and accompanying text.

<sup>44</sup> It seems probable that the 4-4 split among the justices in affirming the court of appeals without opinion, *AMA v. FTC*, 455 U.S. 676 (1982), was occasioned by this issue rather than by the other question in the case, which was the FTC's statutory jurisdiction over the AMA. Similarly, in an earlier case finding state regulation of lawyer advertising to be an unconstitutional restriction of commercial speech, the Court had worried greatly—dividing 5-4—that information about the price of routine legal services might mislead consumers. *Bates v. State Bar of Ariz.*, 433 U.S. 350, 372-75, 386-88, 391-400, 484 (1977).



state laws restricting price advertising have been shown to be costly to consumers,<sup>45</sup> and professional claims that advertising significantly impairs quality have been found to be essentially frivolous.<sup>46</sup> Fortunately, even though it has long been an important goal of all freestanding professions to curb their members' advertising, recent antitrust and first amendment developments have eliminated the most restrictive private and public inhibitions on the advertising of search information by professionals.<sup>47</sup>

Because many professional services—notably legal and medical services—are extremely difficult to evaluate,<sup>48</sup> it would probably be unrealistic to expect consumers of such services to benefit much from advertising that attempts to do more than convey search information. It has been convincingly argued that where consumer goods can be evaluated only on the basis of experience, heavy advertising, however uninformative, is itself a reliable indicator of a business's ability to satisfy its customers.<sup>49</sup> Nevertheless, it seems unlikely that such "image" advertising, arguably valuable to consumers in purchasing so-called experience goods, would serve consumers well in choosing an individual health care provider. The problem lies in the difficulty that consumers have in evaluating many health care services even after extensive experience. Although consumers can gather, pool, and

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<sup>45</sup> Benham, *The Effect of Advertising on the Price of Eyeglasses*, 15 J.L. & ECON. 337 (1972); FTC, STAFF REPORT, ADVERTISING OPHTHALMIC GOODS AND SERVICES (1976). The presence of such laws and other competition-reducing regulation has been attributed to the greater political strength in particular states of professional organizations vis-a-vis commercial purveyors of eyeglasses. See Benham & Benham, *supra* note 34; J. BEGUN & R. FELDMAN, A SOCIAL AND ECONOMIC ANALYSIS OF PROFESSIONAL REGULATION IN OPTOMETRY (1981). Similar findings have been made in studies of advertising regulation in other fields. E.g. CADY, RESTRICTED ADVERTISING AND COMPETITION: THE CASE OF RETAIL DRUGS (1976).

<sup>46</sup> FTC, *supra* note 45. Quality concerns should not be dismissed out of hand; if the consumer can evaluate price information but cannot make judgments concerning quality, less scrupulous providers might perceive opportunities to attract patients without loss of income by imperceptibly reducing quality as well as lowering price, thereby forcing others to do so as well. On the other hand, it is frequently alleged that some risk-averse consumers of medical care rely on price as an indication of quality, suggesting problems with the foregoing scenario and the conclusion that price competition in professional fields leads to suboptimal quality. In addition, in one study more information was found to influence consumers to buy higher quality consumer goods. Sproles, *et al.*, *Informational Inputs as Influences on Efficient Consumer Decisionmaking*, 12 J. CONSUMER AFF. 88 (1978), discussed in Wilde & Schwartz, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 675 n.100 (1979). Although this was not a health care study, it suggests that increasing the supply of information should help consumers address quality/price trade-offs more effectively even in health care, where consumer ignorance can be reduced even though it cannot be eliminated.

<sup>47</sup> See, e.g., *Bates v. State Bar of Ariz.*, 433 U.S. 350 (1977); *AMA v. FTC*, 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided Court*, 455 U.S. 676 (1982). See also Part One, nn. 211-22 and accompanying text.

<sup>48</sup> See Part One, nn. 63-73 and accompanying text.

<sup>49</sup> See NELSON, *Advertising as Information Once More*, in ISSUES IN ADVERTISING: THE ECONOMICS OF PERSUASION (D. Tureck ed. 1978); Nelson, *Advertising as Information*, 82 J. POL. ECON. 729 (1974).

share opinions and their results of experiences with hard-to-evaluate services,<sup>50</sup> such reputation information is only an imperfect protection against the harm that might be caused by certain kinds of advertising.

For these reasons, a policy of limiting professional advertising of complex services to disclosure of verifiable facts may not be unduly harmful to the competitive process. (It is, of course, an entirely separate question whether professional organizations should be entrusted with implementing even these narrow limitations on members' advertising.<sup>51</sup>) Even so, regulatory oversight of professional advertising, like judicial scrutiny of private credentialing standards, should be strictly limited—in this case to preventing overt misrepresentations and advertisements calculated to deceive the proverbial reasonable man.<sup>52</sup> As to other questionable advertising, consumer skepticism should serve as an important protection against acceptance of excessive and unsubstantiated claims, and professional organizations, concerned about competitive inroads, are always free to employ counteradvertising containing warnings and useful substantive information.<sup>53</sup> The main reason for rejecting regulation that chills the making of controversial claims should be clear: Without a dynamic marketplace of ideas, consumers will continue to be uninformed about health care issues that fundamentally concern them and thus be denied access to alternatives that might better satisfy their needs and preferences.

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<sup>50</sup> See Pauly & Satterthwaite, *The Pricing of Primary Care Physicians' Services: A Test of the Role of Consumer Information*, 12 BELL J. ECON. 488 (1981); Darby & Karni, *Free Competition and the Optimal Amount of Fraud*, 16 J.L. & ECON. 67 (1973). Darby and Karni discuss ways in which the market can monitor service delivery and control fraud; Pauly and Satterthwaite demonstrate, however, that consumers can make only limited use of such techniques when markets are large and information is scarce—as when a new family in an urban community seeks a primary caregiver. See also Part One, n. 66 and accompanying text.

<sup>51</sup> Although theoretically such self-regulation could be procompetitive in overcoming a market failure, see Part One, n. 124; *infra* note 108, the rulings permitting the AMA and local societies to control deceptive advertising, see *supra* note 42, are open to question. The FTC's own demonstration of the medical profession's past hostility to competitive advertising demonstrates the great unlikelihood that the profession would in fact use self-regulation to increase consumer confidence in professional advertising and thus its effectiveness as a competitive tool available to professionals. Moreover, the relatively narrow freedom granted medical societies to define deception is broadened in practice because of the difficulty of detecting abuses and because of the "breathing space" that the Supreme Court has regarded as appropriate for self-regulators. See *Silver v. New York Stock Exch.*, 373 U.S. 341, 360 (1962) (discussed in Part One at text accompanying nn. 160-63). Note also that the court of appeals modified the Commission's original order to permit the AMA to prohibit whatever it *reasonably believes* would be deceptive. 638 F.2d at 452.

<sup>52</sup> See *supra* note 43. The FTC's proposed new definition of deception would provide a useful standard. See Part One, n. 197 and accompanying text.

<sup>53</sup> It is to be hoped that tort doctrines on defamation and disparagement will not unduly inhibit vigorous debate. See Part One, nn. 98-100 and accompanying text.

## 2. Information Control Through Credentialing

The probability that professional advertising will not be allowed to set forth anything more controversial than objective, verifiable facts enhances the potential competitive significance of private credentialing. Certification is an objective and readily advertisable fact. Moreover, it can, in principle at least, sum up a great deal about a practitioner's training, experience, skills, methods, and philosophy. If a variety of credentialing systems coexisted, consumers could use them as guides in finding a provider with the desired mix of attributes. It thus appears that much of the complex, particularized information that consumers need in choosing a physician or other provider could be supplied more readily and in a more useful and credible form through competing credentialing systems than through other available channels. By the same token, practitioners with special qualifications should find credentialing a dignified and efficient way of differentiating themselves from their competitors.

### a. Specialty Certification as a Tactic for Suppressing Information

Formal private credentialing in medicine has long been virtually synonymous with specialization, which is the most obvious basis on which physicians can be differentiated. Although private certifiers could easily supply information on a variety of other points important to consumers in selecting a physician, they have rarely done so. The reason appears to be that the medical profession has authorized the differentiation of physicians along specialty lines but on no other basis. Indeed, the history of specialization in medicine in the United States has been a continuous struggle by the profession to define the minimum amount of differentiation that it would have to tolerate in order to maintain its solidarity.<sup>54</sup> When specialization was first encountered in medicine, professional interests feared that the implicitly invidious distinctions being drawn by physicians claiming specialized skills would divide the profession and intensify competition. Efforts were therefore made to suppress the trend toward specialized practice. It quickly became clear, however, that the profession could not hope to maintain indefinitely the myth that all physicians were equal in all fields. A new strategy had to be developed.

Specialty certification was well designed by organized medicine to reestablish the homogeneity of competing professionals and to restore control over the entrepreneurial desire of individual physicians to differentiate themselves from their competitors. The first requirement of a successful strategy was to control the proliferation of specialties by defining them, by recognizing only a limited number, and by standardizing training

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<sup>54</sup> See generally R. STEVENS, *supra* note 11.

within each field. Second, the newly acknowledged differences among physicians had to be publicized in a form that satisfied the specialists' desire to be set apart. Gradually, the specialty boards were molded into a common enterprise to achieve these objectives, thereby containing the divisive forces associated with specialization. In the early days, the struggle was between general practitioners and specialists; comparable conflicts, now well contained, go on today within the various specialties themselves, as increasing numbers of subspecialists seek, and occasionally obtain, limited recognition for themselves.<sup>55</sup>

With this background, the specialty boards can be seen, despite their role in generating information of obvious value, as playing a vital part in a larger professional strategy of withholding information from consumers. The information that they supply can usefully be viewed as escaping through a kind of safety valve that is needed to prevent competitive pressures for differentiation from shattering the profession's carefully constructed bulwarks against economic competition. Once specialty certification is seen in this light, its procompetitive, market-improving features seem much less impressive than previous discussion made them appear. By standardizing physicians as much as possible within specialties, the profession has made certain that few practitioners have or can easily acquire unique skills that they will want to publicize. In addition, by preempting the certification role, the profession has defined the accepted manner of communicating information about one's specialty.<sup>56</sup> Thus, the careful provision made by the professional cartel for differentiating physicians along specialty lines has actually restricted the nature and amount of information available to help consumers in choosing a particular specialist.<sup>57</sup>

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<sup>55</sup> See Part One, nn. 40-43 and accompanying text.

<sup>56</sup> For a first amendment case striking down state bar rules limiting the fields in which lawyers could claim to specialize, see *In re RMJ*, 102 S. Ct. 929 (1982). In an antitrust case, *Nara v. American Dental Ass'n*, 526 F. Supp. 452, 458 (W.D. Mich. 1981), the ADA was allowed to prohibit plaintiff from advertising himself as a specialist in an area "in which no special training or education has been prescribed." Although the plaintiff in that case was probably engaged in deception in holding himself out in the self-styled specialty of "oramedics," the court appeared to permit the ADA to prohibit the advertising of any specialty not ADA-approved. Such a ruling would be wrong precisely because the professional canon against such advertising forbids more than deception. Indeed, an agreement among professionals to advertise only agreed-upon specialties would appear to be a naked restraint not redeemable—as an agreement not to advertise deceptively might be—as an attempt to overcome an identifiable market failure. See *supra* note 51. See also Part One, n. 175.

<sup>57</sup> This demonstration of the darker side of the medical profession's initiative in supplying the public with useful information has a parallel in recent antitrust treatment of the profession's collective actions to contain the cost of medical care. Though applauded by many as being in the public interest, profession-sponsored cost containment efforts have been criticized by others as being nothing more than strategic retreats by a professional cartel, the minimum concessions needed to preserve the profession's integral character in the face of powerful competitive pressures. *E.g.*, Havighurst & Hackbarth, *Enforcing the Rules of Free Enterprise in an Imperfect Market: The Case of Individual Practice Associations*, in *A NEW APPROACH*

Specialty certification is apparently destined to become less useful to consumers in the future than it has been in the past. Originally, consumers found it helpful to know which physicians holding themselves out as specialists had undertaken to qualify themselves in the specialty according to professional guidelines. Now, however, specialty certification is becoming nearly universal, with few uncertified specialists destined to survive in any field.<sup>58</sup> Under these circumstances, board certification will no longer be of much help to consumers in choosing among competitors within the same field. Though continuing to exclude a handful of doctors, mostly foreign-trained, from certified status, board certification will serve primarily to divide physicians along vertical lines. Like trademarks in industrial settings, certification will soon do little more than identify a practitioner as a product of the profession-approved training process. In the absence of alternative production processes and alternative credentials, the consumer will be left without much real choice and without much information to use in making the few choices that he has.

#### b. Monopoly Versus Competition in Credentialing

Despite the desirability from the consumer's standpoint of competition among credentialing bodies, it rarely occurs. The medical profession's control of specialty certification through the American Board of Medical Specialties (ABMS) has discouraged the development of unapproved certification schemes, which have generally failed to obtain significant recognition.<sup>59</sup> An important prerequisite for admitting a new specialty to the ABMS has been its acceptability to existing boards, and this has usually meant not only the avoidance of duplication but also the elimination of any

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TO THE ECONOMICS OF HEALTH CARE 377 (M. Olson ed. 1981); Weller, *supra* note 4. These observers argue that profession-sponsored cost containment programs are useful to the profession in discouraging competitive initiatives from which consumers would ultimately benefit more than they do from whatever concessions are wrung from the cartel. In *Arizona v. Maricopa County Med. Soc'y*, 102 S. Ct. 2466 (1982), the Supreme Court held that a powerful professional organization violated the firm (per se) antitrust rule against price-fixing when it attempted to establish maximum limits on professional fees. See *infra* notes 105-07 and accompanying text. Although the dissenting Justices thought that this holding was perverse and anticonsumer, removal of the profession as the arbiter of such economically important matters is probably essential if the public is soon to enjoy the full benefits of competition (through such innovations as those noted *supra* note 30). Unlike fixing maximum prices, specialty certification does not come within any of the established per se rules of antitrust law and will enjoy, as we have seen, some judicial deference insofar as it is providing information of use to consumers. Nevertheless, specific recognition of its anticompetitive potential should facilitate intelligent application of the rule of reason.

<sup>58</sup> See Part One, nn. 21-25, 46 and accompanying text.

<sup>59</sup> See Part One, nn. 18-19 and accompanying text..

overlap at all between boards and among specialists of the recognized types.<sup>60</sup> The ABMS system thus ensures both that the dominant boards do not compete among themselves and that they do not face effective competition from independent credentialers.<sup>61</sup> Similarly, the specialists they recognize rarely find themselves in competition across specialty lines. Comparable conditions exist in the field of dentistry, where the American Dental Association (ADA) presides over the delineation of specialties.<sup>62</sup>

Although examples of competition in credentialing can be found in allied health fields, certification by a single body is usually the rule and always the ideal.<sup>63</sup> The extensive participation of the medical profession in the credentialing of allied occupations exerts a strong unifying influence on the entire field but also sets up some antagonisms, which have sometimes caused alternative accrediting or certifying bodies to be established.<sup>64</sup> Even so, medicine's ideology tends to dominate the credentialing of allied personnel even when physicians do not control it, because most such personnel must practice in settings where that ideology is well entrenched.<sup>65</sup> Only in fields where independent practice is a possible option, such as physical

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<sup>60</sup> See Part One, nn. 38-43 and accompanying text.

<sup>61</sup> On non-ABMS boards, see Part One, nn. 18-19 and accompanying text.

<sup>62</sup> See *Nara v. American Dental Ass'n*, 526 F. Supp. 452 (W.D. Mich. 1981), discussed *supra* note 56.

<sup>63</sup> Other health professionals echo physicians in decrying the duplication and confusion engendered by the existence of more than one credentialing body in a given field. See, e.g., STUDY OF ACCREDITATION OF SELECTED HEALTH EDUCATION PROGRAMS (SASHEP), COMMISSION REPORT (1972) (identifying duplication as a credentialing problem); INVITATIONAL CONFERENCE ON CERTIFICATION IN ALLIED HEALTH PROFESSIONS, CERTIFICATION IN ALLIED HEALTH PROFESSIONS (1971) (especially the Statement of the American Society of Medical Technologists, *id.* at 68, decrying competition between ASMT and the American Society of Clinical Pathologists, a physician group, in certifying laboratory personnel). The proposed development of national credentialing standards for health personnel and the establishment of the National Commission for Health Certifying Agencies (NCHCA) also reflect the desire of other health professions for uniformity and centralization. See, e.g., PUBLIC HEALTH SERVICE, CREDENTIALING HEALTH MANPOWER 7-11 (1977), *quoted infra* in text accompanying notes 139-41.

<sup>64</sup> Competing credentialing or accrediting bodies coexist in several occupations. For example, in the area of medical technology, the National Commission for Health Certifying Agencies (NCHCA) accredits at least three certifiers whose personnel categories overlap to some degree. The AMA's ALLIED HEALTH DIRECTORY (10th ed. 1981) lists three bodies certifying nuclear medicine technologists and two that certify several types of medical laboratory personnel. One of these is the American Society of Clinical Pathologists. See *Higgins v. American Soc'y of Clinical Pathologists*, 51 N.J. 191, 195, 238 A.2d 665, 667 (1968). The others are without physician affiliation. There are also two competing accreditors of physical therapy education programs—one affiliated with physicians, the other independent. See discussion *infra* note 164 and accompanying text.

<sup>65</sup> See generally Dolan, *Antitrust Law and Physician Dominance of Other Health Practitioners*, 4 J. HEALTH POL., POL'Y & L. 675 (1980).

therapy or clinical psychology, is there a real opportunity for establishing a credentialing system that rejects the medical status quo.<sup>66</sup>

Certain consumer-protection arguments might be offered for suppressing additional certifiers of personnel in health care fields. Many observers profess concern that consumers would be confused by the possibly conflicting information supplied by competing systems, but there is no credible evidence to support this argument for curbing the information supply.<sup>67</sup> The other arguments that might be made under the consumer-protection heading all focus on possibilities for deception and thus are similar to the arguments for limiting advertising by professionals. Nevertheless, the danger of actual harm to individual consumers from deceptive credentialing seems substantially less than from false advertising. Truly deceptive credentialing can be more easily policed by public authorities than can occasional ads.<sup>68</sup> Moreover, competition should serve as a better check on deceptive credentialing than on deceptive advertising.<sup>69</sup> Collec-

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<sup>66</sup> For discussion of physical therapy, see *infra* note 164 and accompanying text. On psychologists, see *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980). Osteopaths and chiropractors are independent practitioners with their own credentialing systems. See *infra* note 80.

<sup>67</sup> Some consumer and marketing literature claims that consumers suffer from "information overload" as the number of items relevant to a purchasing choice is increased. One study concluded that, given a fixed interval in which to choose a brand of detergent, an increase in the total number of information bits (number of brands times information bits per label) increased decision making effectiveness up to a point but that, beyond that point, decision making effectiveness decreased—that is, fewer consumers chose the brand that best met their previously ascertained needs. Jacoby *et al.*, *Brand Choice Behavior as a Function of Information Overload*, 11 J. MKT. RESEARCH 63 (1974); Jacoby *et al.*, *Brand Choice Behavior as a Function of Information Overload: Replication and Extension*, 1 J. CONSUMER RESEARCH (1974). However, this finding (which appears, incidentally, to differ from Pauly & Satterthwaite's observation, *supra* note 50, that decreasing the information available *per option* decreases consumers' ability to affect the price of physician services) has been criticized. See Wilde & Schwartz, *supra* note 46 at 630, 675-76 & n.100 (1979), and sources cited therein. For one thing, the time constraint is unrealistic because consumers given more information to evaluate would anticipate a greater payoff from investing more time. In addition, the research ignores the influence of a few informed, searching consumers in policing the market, inducing producers to offer better value to all. *Id.* at 638, 649-50; Pauly, *Is Medical Care Different?*, in FTC, *COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE* 19, 24 (1978). Finally, even if providing more information "bits" risks overloading the consumer, credentialing and accrediting would seem exempt from this criticism precisely because they serve the valuable purpose of summarizing and interpreting a great deal of raw information, giving the consumer only the "bottom line" conclusion. Although competing credentialers or accreditors would themselves have to be evaluated by consumers, they nevertheless provide an efficient response to the consumer's problem of getting and handling information.

<sup>68</sup> See discussion of the FTC's potential for controlling deceptive credentialing in Part One, text accompanying nn. 180-97.

<sup>69</sup> A bona fide credentialing body depends on its reputation and would be unlikely to jeopardize it by engaging in deception for the short-term advantage of its sponsors. Some individual professional advertisers—e.g., cosmetic plastic surgeons, who have little repeat business and rely on self-referrals—might be less concerned about building long-standing goodwill.

tive counteradvertising, though difficult to imagine owing to our lack of experience with competition among credentialed groups, would seem to have some potential value in helping consumers appreciate the characteristics and shortcomings of particular credentialing systems. Furthermore, many users of credentials, such as insurers, institutional providers, and referring physicians, are quite sophisticated. In some fields these users represent the only market for allied health personnel, and in other fields such users' faith or lack of faith in particular credentials could easily become known to consumers. Objective evaluations of competing credentialing schemes could come from other sources as well. Not only could one expect to find programs for formally accrediting certifying bodies, but consumer groups and the media could also provide helpful indications of the meaning and reliability of certain credentials.

The other arguments that might be made for monopoly in credentialing all appear to reduce to the claim that there is only one right way to assess competency and therefore no need for duplicative systems. As in other areas of economic activity, there should be no objection if a single credentialing system should emerge triumphant in a particular field by virtue of its superior performance and public acceptance.<sup>70</sup> In some fields credentialing may prove to be a natural monopoly, so that competition between parallel systems could not be long sustained.<sup>71</sup> Even so, there should be concern about how a particular credentialing monopoly was obtained and perpetuated.<sup>72</sup> Unless opportunities to create new credentialing systems are kept open, there is no assurance that the system that exists is in fact the one that best serves consumers' needs.<sup>73</sup>

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<sup>70</sup> In the leading case of *United States v. Aluminum Co. of America*, 148 F.2d 416, 430 (2d Cir. 1945), the court observed that monopoly might be attributable to "superior skill, foresight and industry" and that "[t]he successful competitor, having been urged to compete, must not be turned upon if he wins." Although the holding in *Alcoa* may not have been entirely true to this dictum, recent cases have been more respectful of success. See Part One, n. 209.

<sup>71</sup> To the extent that information is a public good that can be used by everyone once it is produced and published, it makes no sense to have two sources producing the same information. On the other hand, different entities might be interested in different things and thus not duplicate each other. Thus, natural monopoly situations would exist only where the information that consumers seek is simple and straightforward or where there is a near-universal preference for certain information. See *infra* text accompanying note 74.

<sup>72</sup> One can imagine pursuing a credentialing monopoly under section 2 of the Sherman Act, 15 U.S.C. § 2 (1981). Although this Article develops a number of legal theories under section 1, it stops short of discussing section 2 issues in detail. Subsequent discussion of relevant markets in which to examine the effects of mergers and joint ventures would be relevant to section 2 theories, see *infra* notes 144-46, 161-62 and accompanying text, but little attention has been given to identifying exclusionary practices (such as market-division agreements) that might warrant the invocation of section 2. It is not intended that the possibility of section 2 actions be ruled out, however.

<sup>73</sup> It is important to observe that competition in credentialing can be beneficial even if it takes only the form of potential competition. See *infra* text accompanying note 157. This



One should not conclude too quickly that monopoly is the natural condition in all markets for information concerning health care personnel and that active competition would be exceptional or merely a transitory phase. Monopoly is likely to occur only where the information that users require is relatively simple and objective.<sup>74</sup> If different users require different information, they are not likely to be satisfied by the information emanating from a single source, especially if that source is dominated by providers more interested in preventing differentiation among themselves than in facilitating it. The most troublesome credentialing monopolies would be those that employ criteria differing materially from those that a substantial body of consumers would employ in making their choices.

Because there frequently is more than one right way to define acceptable practitioners, all explicit and implicit claims of technical superiority should be regarded with suspicion and subjected to a continuing market test. Thus, to allow for the possibility that users might judge the quality of care by differing standards or values, providers should be free to compete by appealing to subsets of the public by means that include establishment of independent credentialing systems. Many consumers, given a clear choice, might decide, for some purposes at least, against patronizing the "best" doctors as judged by the medical profession's standards and might instead seek out physicians distinguished on some other basis. Ideally, credentials would signal philosophical differences among practitioners, provide guidance in weighing the significance of price differences among providers, and assist consumers in satisfying their other preferences.

If professional interests monopolize private credentialing, it seems certain that only minimum disclosures will be made. Because the information generated by credentialing is a public good that cannot be sold to those who benefit from its use and moreover is a costly undertaking when it is

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observation underscores how essential it is that entry into the business of supplying consumer information not be artificially restricted.

<sup>74</sup> See *supra* note 71. The situation here is essentially different from that prevailing where two athletic leagues offer competing exhibitions of skill in the same sport; such competition has always proved unstable, gravitating toward merger of the leagues, because of the public's demand for a single champion and a definitive ranking of teams. Cf. J. WEISTART & C. LOWELL, *THE LAW OF SPORTS* 724-31 (1979). If a definitive ranking were the object in personnel credentialing, a single certifying body could satisfy the information need. But the desire for a definitive minimum standard usually originates with the industry itself rather than with the consumer. For a striking example, see *infra* note 156. Whereas the industry is interested only in eliminating low-cost competitors without drawing any other distinctions, the consumer interest lies in having reliable information about as many differences as possible.

Although some users of information yearn to be told definitively who is qualified to perform particular tasks, see Part One, text accompanying nn. 74-81; *supra* notes 27-32 and accompanying text, their desire to be relieved of the responsibility for making choices need not be respected at the expense of allowing natural diversity in the marketplace to be suppressed.

done well and unreliable when it is done cheaply, it is not certain that competitive credentialing would ensue even if market conditions permitted it. Nevertheless, the public has a substantial stake in ensuring that free market conditions prevail in the vital business of providing information useful in differentiating among health care practitioners. An unearned and unaccountable professional monopoly of this endeavor, though ostensibly undertaken to protect consumers, protects no one except the dominant professionals themselves—against having to measure up to new credentialing standards that emanate from consumer rather than professional concerns.<sup>75</sup>

### C. FOUNDATIONS OF PROFESSIONAL MONOPOLY

The foregoing discussion reveals that organized professions in the health care field have assumed important decision making powers and have frequently limited the availability of information and opinion that might enable or induce consumers and their agents to assume larger decision making roles. The full significance of the strategies described can be grasped only by understanding them in the context of other professional policies and practices that are also aimed at centralizing decision making in professional hands. Most of the overview provided here relates to the medical profession and to the foundations of its monopoly—that is, its carefully nurtured professional ideology and its power to restrain trade at strategic points. The medical profession is not unique in its endeavors, however. Other professions have maintained comparable tenets and pursued comparable strategies to narrow the scope of consumer choice. In the health care field, most occupations have, willingly or unwillingly, “allied” themselves with the medical profession and have fostered similar ideologies and pursued similar policies within their allotted territories.

#### 1. Ideology in Medical Care

The medical profession’s success in controlling the flow of information to consumers and in dominating medical-economic decision making has been achieved in part by fostering an ideology of medical care that denies the relevance of many of the questions that consumers might ask and the

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<sup>75</sup> See *Public Citizen Health Research Group v. Committee on Med. Discipline*, 573 F.2d 863, 865 n.2 (4th Cir. 1978), where the court stated:

The commission held the opinion that permitting [consumer directories to give listed physicians] ratings “would encourage physicians to compete among themselves to meet the standards selected by the compilers of a directory” instead of “the standards of good care established by [their] peers, by the law, and by [their] own best medical judgment.”

The issue of professional accountability was thus sharply drawn.

appropriateness of many of the decisions that they might seek to make.<sup>76</sup> This ideology considers consumers and lay-controlled intermediaries incompetent decisionmakers on many points and maintains that the treating physician and the profession itself are the consumer's best allies in his quest for high-quality health services at reasonable cost.<sup>77</sup> A crucial belief is that the quality of care overrides all other considerations and can be judged only by professionally developed norms and standards. These norms and standards are in turn deemed to be rooted in hard medical science. The claim that clinical decisions are dictated by science—and never by habit or folklore or economic self-interest—has served the profession well in maintaining its authority and in building ideological resistance to any development threatening that authority.<sup>78</sup> In the recent case of *Wilk v. AMA*, a federal appeals court was so impressed by the profession's dedication to "scientific method" that it gave certain powerful medical associations a chance to satisfy a jury that their ethical boycott of chiropractors was predominantly inspired not by economic considerations but by their perception of chiropractic as an "unscientific cult."<sup>79</sup>

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<sup>76</sup> For a thoughtful and well-referenced discussion of ideology in medical care, see Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 WIS. L. REV. 1, 5-6, 21-27. Addressing the subject in terms of the sociology of knowledge, Kissam draws an interesting parallel between the ways in which ideology influences medical practice and the influence of intellectual "paradigms" in the history of science, as observed by Thomas Kuhn. T. KUHN, *THE STRUCTURE OF SCIENTIFIC REVOLUTIONS* viii, 10, 175 (2d ed. 1970). Though soundly-based paradigms are valuable in focusing energies in the pursuit of scientific progress, they may also stultify progress by impairing the receptivity of a scientific establishment to new challenges and new ideas. Physicians, even though they are not research scientists, tend to share a common view of their discipline as a result of their medical training and the continuing influence of professional institutions. Their commonly-held views, or paradigms, have undoubtedly inspired medical research and the development and dissemination of much useful knowledge, but, in conjunction with the operative economic incentives, they have also discouraged interest in evaluating the cost-effectiveness and other implications of new therapies and technologies and in developing and adopting cost-reducing measures.

<sup>77</sup> In an early article, economist Kenneth Arrow offered a justification for the medical profession's assumption of the power to define ethical behavior and even expressed admiration for the profession's efforts as a successful societal solution to the problem of consumer ignorance. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). Sociologist Paul Starr has recently rendered a useful critique of Arrow's thesis, observing that it was not society but the medical profession itself that defined the problem and designed the solution. P. STARR, *supra* note 4, at 225-27. In view of the numerous other available techniques for coping with consumer ignorance, see Part One, nn. 63-73 and accompanying text, one should not be uncomfortable with rejecting Arrow's analysis and the profession's self-serving approach.

<sup>78</sup> For evidence of the lack of scientific basis for many clinical decisions, see, e.g., OFFICE OF TECHNOLOGY ASSESSMENT, *THE IMPLICATIONS OF COST-EFFECTIVENESS ANALYSIS OF MEDICAL TECHNOLOGY* (1980); J. BUNKER, *et al.*, *COSTS, RISKS, AND BENEFITS OF SURGERY* (1977); Eddy, *Clinical Policies and the Quality of Clinical Practice*, 307 NEW ENG. J. MED. 343 (1982). The case for fostering decentralized decision making on technical issues in medicine is developed in Havighurst, *supra* note 2.

<sup>79</sup> 719 F.2d 207, 213 (7th Cir. 1983). The court's willingness to let a jury find a noncom-

The success of the medical profession in maintaining an ideological monopoly can be illustrated by noting some exceptions that help to prove the extent of the profession's rule. Perhaps the most obvious example of ideological competition in the medical care arena is the long struggle between licensed chiropractors and osteopaths, on the one hand, and practitioners of traditional allopathic medicine, on the other.<sup>80</sup> Intense

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mercial purpose despite the medical profession's conflict of interests would seem to ignore the tendency in human nature and of organized interest groups to espouse principles consonant with self-interest. See Part One, nn. 123-26 and accompanying text. In suggesting that the boycott of chiropractors might be justified, the opinion of the court of appeals departs sharply from the general rule that compatibility with competition is the controlling question in a restraint-of-trade case and that restraints, including boycotts, cannot be upheld on public interest grounds. See *infra* notes 100-10 and accompanying text; Part One, text accompanying nn. 137-53. The court sought, however, to distinguish between a boycott for a "public-interest motive," which would be unlawful as an attempt to reverse by private action the legislature's recognition of chiropractic, and a boycott expressing a "patient care motive" embodying the medical profession's commitment to science. Not only is this distinction exceedingly fine, but it is hard to agree that it should save the boycott in the *Wilk* case, which among other things systematically denied to the patients of chiropractors the benefits of the very scientific medicine that the physicians touted so highly.

More fundamentally, judicial tolerance for professional ethics embodying agreements not to compete in particular ways can result only from a determination that, in antitrust contemplation, the organized profession is a legitimate decision making entity that is entitled, like a sports league or trademark owner, to control by coercive measures (that is, by reasonable ancillary restraints) the quality, integrity, and uniformity of its products. Cf. *Molinas v. National Basketball Ass'n*, 190 F. Supp. 241 (S.D.N.Y. 1961); *Smith v. Pro Football*, 593 F.2d 1173 (D.C. Cir. 1978); *Tripoli Co. v. Wella Co.*, 425 F.2d 932 (3d Cir. 1969), *cert. denied* 400 U.S. 831 (1970). Yet, organizations of competing professionals that offer no different product and do not integrate services make a weak claim of being procompetitive, efficiency-enhancing joint ventures. See *Arizona v. Maricopa County Med. Soc'y*, 102 S. Ct. 2466 (1982). Even if a professional organization were thought helpful in overcoming market failure (e.g., the adverse consequences of consumer ignorance), the possession of undue market power by that organization, when organization on a smaller scale (e.g., through such vehicles as HMOs) was feasible, should settle the matter. See *infra* notes 100-10 and accompanying text. If it is desirable that antitrust law retain coherence, see *infra* text accompanying notes 100-03, the *Wilk* opinion's tolerance for professional boycotts must be wrong.

<sup>80</sup> On the struggle between osteopathic and allopathic physicians, see generally Blackstone, *Competition Within the Physicians' Services Industry: Osteopaths and Allopaths*, 8 AM. J.L. & MED. 137 (1982); *The AMA and the Osteopaths: A Study of the Power of Organized Medicine*, 22 ANTITRUST BULL. 405 (1977). The gradual diminution of differences between the professions and some AMA efforts to absorb osteopathy have resulted in virtual merger in some areas, particularly as regards licensure. See discussion *infra* note 147 and accompanying text. However, in most state licensure schemes the distinction is preserved. See *Maceluch v. Wysonog*, 680 F.2d 1062 (5th Cir. 1982); *Eatough v. Albano*, 673 F.2d 671 (3d Cir. 1982); *Procario v. Ambach*, 561 F. Supp. 804 (N.D.N.Y. 1983); *Arizona Bd. of Osteopathic Examiners v. Ferris*, 20 Ariz. App. 535, 514 P.2d 288 (1973).

On chiropractors, see, e.g., *Wilk v. AMA*, 719 F.2d 207 (7th Cir. 1983) (discussed *supra* note 79 and accompanying text); *Ballard v. Blue Shield of W. Va.*, 543 F.2d 1075 (4th Cir. 1976); *In re Application of Consumers Union*, 495 F. Supp. 582 (S.D.N.Y. 1980); *Health Care Equalization Comm. v. Iowa Med. Soc'y*, 501 F. Supp. 970 (S.D. Iowa 1980); *Brodie v. State Bd. of Med. Examiners*, 177 N.J. Super. 523, 427 A.2d 104, *cert. denied*, 87 N.J. 386, 434 A.2d 1068 (1981). See also E. RAYACK, *PROFESSIONAL POWER AND AMERICAN MEDICINE: THE ECONOM-*

value-oriented competition also exists in the field of maternity care, where options range across a philosophical spectrum all the way from home birthing attended by midwives to hospital-oriented obstetrical care using sophisticated technology.<sup>81</sup> Numerous other examples of competition between differing ideologies exist at various points along the borders of medical practice, where nonphysician providers have sought to encroach upon physicians' territory.<sup>82</sup> In addition to these peripheral conflicts, some value-oriented competition has also sprung up in the heart of medicine's domain as a result of the establishment and expansion of prepaid group practices. To varying degrees, these relatively freestanding delivery systems maintain views of medical care that differ from the dominant philosophy.<sup>83</sup>

Despite these and other possible examples of the coexistence of different philosophies and approaches in the health care sector, ideological competition is unusual. Historically, outbreaks of such competition were ruthlessly suppressed, with the result that the hegemony of the dominant ideology was seldom challenged. Under the banners of "medical science," "quality of care," and "professional prerogative," the medical profession was able to repel most attacks along its borders, to force many of its antagonists into alliances, and to confine other would-be invaders to narrow enclaves. In addition, the profession established in the medical heartland a regime that, while tolerating certain kinds of diversity in the name of pluralism, suppressed dissent that threatened the profession's ideological paradigms, its solidarity, or its economic sustenance.<sup>84</sup> Such one-party rule has never been compatible with free competition in the realm of ideas and values or with economic competition. Only recently have the antitrust laws become available to facilitate competitive challenges to the ruling powers.

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ICS OF THE AMERICAN MEDICAL ASSOCIATION 253-58 (1967); Kirchner, *Will These M.D.s Win a Counterattack on Chiropractors?*, MED. ECON., July 19, 1982, at 92; Mettera, *Chiropractors and M.D.s: The Referral Doors Inch Wider*, MED. ECON., July 6, 1981, at 157; Allen, *Medicine vs. Chiropractic: Our Leaders Let All of Us Down*, MED. ECON., Sept. 17, 1979, at 133.

<sup>81</sup> On the range of choice in obstetric care generally, see, e.g., S. ARMS, *IMMACULATE DECEPTION* (1975); Kramer, *Revolution in the Delivery Room*, N.Y. Times Magazine, July 11, 1976, at 18. For an interesting study of the issues raised by one competing maternity model—nurse-midwifery care in freestanding obstetrical centers—see *The Childbearing Center Case Study*, in 2 LEWIN REPORT, *supra* note 31.

<sup>82</sup> Acupuncture, naturopathy, and lay midwifery are among the numerous nontraditional therapies that have gained adherents. See generally Forster, *How Much of Your Turf Do the Non-M.D. Doctors Have?*, MED. ECON., Sept. 27, 1982 at 167; Carlova, *Will Low-Cost "Healers" Replace M.D.s?*, MED. ECON., Aug. 9, 1982, at 84; Dolan, *The Law and the Maverick Health Practitioner*, 26 ST. LOUIS U.L.J. 627 (1981); Note, *Restrictions on Unorthodox Health Treatment in California: A Legal and Economic Analysis*, 24 U.C.L.A. L. REV. 647 (1977).

<sup>83</sup> See *supra* note 19.

<sup>84</sup> A particularly instructive professional tactic was the early ethical injunction against physician criticism of other physicians and of the profession as a whole. Rationales for suppressing private awareness of and public debate about professional issues included the need to maintain professional solidarity and the public's trust in the profession as an entity. See J. BERLANT, *supra* note 4, at 72-73, 75-79.

Much of the medical profession's success has resulted from the general public's acceptance of it as a single entity. It is not clear, however, whether public acquiescence in the profession's preferred view of itself was entirely voluntary, because professional actions on many fronts have long prevented the public from dealing with the health care "system" (the unitary term is significant) on any other basis. Whatever the origin of this unitary view, it is currently reflected in a tendency to think that competition in health care simply means introducing "alternative delivery systems" (this term, too, signifies a great deal).<sup>85</sup> Likewise, osteopathy and chiropractic are frequently approved as philosophic competitors of the dominant allopathic philosophy.<sup>86</sup> As valuable as competition among competing delivery systems and among competing philosophic schools may be, there is also an immense potential for competition, ideological and otherwise, within the dominant system. Much of the analysis in this Article is predicated on the desirability of, and legal necessity for, letting ideological competition operate within medicine's domain and letting consumers rather than profession-approved arbiters have the final say. Many of the medical profession's internal policies and practices are calculated to maintain an ideological consensus, to suppress outbreaks of dissent, and to deny consumers the chance to choose.

## 2. Other Strategies of the Professional Cartel

In addition to standardizing health care personnel and services and controlling the supply of information to consumers, the medical profession has used other monopolistic tactics. Many, indeed most, of these other techniques for restraining free competition can also be understood as attempts to narrow the range of issues on which consumers can and do make judgments. At each decision-making point, the profession has found

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<sup>85</sup> Market reformers tended to stress the value of HMOs as competitors of the dominant system because prepaid group practice had a track record that could easily be appreciated. *See, e.g.,* A. ENTHOVEN, *HEALTH PLAN* (1980); FTC, *STAFF REPORT ON THE HEALTH MAINTENANCE ORGANIZATION AND ITS EFFECTS ON COMPETITION* (1977); P. ELLWOOD, *et al.*, *THE HEALTH MAINTENANCE STRATEGY* (1970); McClure, *On Broadening the Definition of and Removing Regulatory Barriers to a Competitive Health Care System*, 3 J. HEALTH POL., POL'Y & L. 303 (1978); Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROBS. 716 (1970). The emphasis on "alternative delivery systems," however, appeared to confirm the monolithic character of the traditional system and resulted in undue neglect of the potential for change within that system. *See* C. HAVIGHURST, *DEREGULATING THE HEALTH CARE INDUSTRY* 111-17 (1982); Havighurst & Hackbarth, *Private Cost Containment*, 300 NEW ENG. J. MED. 1298 (1979). Current developments in the private sector, *see, e.g., supra* note 30, can be seen as filling in the spectrum between group practice on the one hand and traditional health insurance on the other.

<sup>86</sup> *See supra* note 80. For reservations about the implicit conception of medicine as a single school or entity, *see supra* notes 78-79.

ways to limit the consumer's ability, either directly or through others acting on his behalf, to obtain, evaluate, and act on information.

One strategy employed by organizations of physicians and other independent practitioners has involved forestalling the emergence of independent entities that might act, in effect, as knowledgeable decision-making agents of the consumer in procuring professional services. The medical profession's vigorous insistence on maintaining free choice of physician long served to prevent third parties from intervening to assist the consumer in making difficult choices.<sup>87</sup> Likewise, professional opposition to "corporatized practice" by lay-controlled intermediaries<sup>88</sup> and ethical prohibitions against cooperating with such intermediaries<sup>89</sup> have hampered the introduction of sophisticated middlemen who could reduce the market power enjoyed by professionals in dealing with ill-informed consumers. Group practice and the use of trade names were discouraged for reasons related to the economic threat posed by a competitor that is both highly visible to consumers and capable of expanding to capture the benefits of any goodwill that it develops.<sup>90</sup> Other ways in which the dominant health professions have kept independent third parties from effectively purchasing services include direct control of third-party financing plans, such as Blue Shield and Delta Dental plans,<sup>91</sup> and boycotts aimed at third parties that deny free choice of provider<sup>92</sup> or intrude into the provider-patient relationship by questioning fees or spending decisions.<sup>93</sup>

A vital feature of the professional strategy of keeping economically important decisions in professional hands has been control of information that might serve to facilitate effective purchasing decisions by third parties. Dentists have been found guilty of conspiring to deny dental insurers access to dental x-rays needed to determine the appropriateness of treat-

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<sup>87</sup> See Olson, *supra* note 8; Havighurst, *supra* note 27.

<sup>88</sup> E.g., *AMA v. United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943).

<sup>89</sup> E.g., the ethical prohibition of "contract practice" by physicians that was condemned by the FTC, along with advertising restrictions, in the 1979 *AMA* case. 94 F.T.C. at 1011-18.

<sup>90</sup> The medical profession's historic dislike for group practice can be explained under the theory espoused by Pauly & Satterthwaite, *supra* note 50, that competition among a large number of solo practitioners is ineffective because of the difficulty of getting comparative information. The ability of a group practice to build and exploit a reputation thus makes it a vehicle for intensifying competition. On legislation restricting professionals' use of trade names, see *Friedman v. Rogers*, 440 U.S. 1 (1978).

<sup>91</sup> See generally *FTC, supra* note 21; *FTC, PHYSICIAN AGREEMENTS TO CONTROL MEDICAL PREPAYMENT PLANS*, 46 Fed. Reg. 48,982 (1981).

<sup>92</sup> See, e.g., *In re Michigan State Med. Soc'y*, [1979-83 Transfer Binder] *TRADE REG. REP. (CCH)* ¶ 21,991 (Feb. 17, 1983) (final order to cease and desist). On professional boycotts generally, see Havighurst, *supra* note 27, at 344-62.

<sup>93</sup> See, e.g., *Goldberg & Greenberg, The Effect of Physician Controlled Health Insurance: U.S. v. Oregon State Medical Society*, 2 J. HEALTH POL., POL'Y & L. 48 (1977).

ment.<sup>94</sup> Maintenance of profession-sponsored peer-review bodies that perform the essential tasks of policing excessive fees and utilization has served the dual professional purposes of maintaining control of vital quality and cost data and preempting decision making in areas where competition among third parties would create pressures on providers.<sup>95</sup> Recent struggles over the confidentiality of peer-review information are an important sign of the medical profession's recognition that data control is power, particularly in this computer age.<sup>96</sup> It should be obvious that cost information and data permitting the skills of individual professionals to be judged on the basis of actual outcomes of care—rather than on the basis of educational hurdles surmounted and examinations passed—are the ultimate keys to matching individuals efficiently with the professional tasks to be performed.

Perhaps the greatest coup of the medical profession has been in minimizing the significance of the cost factor in doctor-patient decision making. This was accomplished by ensuring that public and private financing programs were designed so that influences from the demand side of the market did not act as constraints on the quality, quantity, and price of services.<sup>97</sup> In addition to permitting increases in both fees and the number of services provided, the removal of cost factors weakened forces that threatened to break down the profession's monolithic structure and ideological integrity. Without cost as a consideration, there were fewer grounds on which opinions on professional matters could reasonably differ; issues were therefore more easily framed as technical questions fit for resolution by a technical elite.<sup>98</sup> In a proper analysis, of course, issues of dollars and cents are inseparable from opinions and preferences about what medical care should do for people and how it is best provided. Thus, the medical profession's efforts on the economic front depend upon, and

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<sup>94</sup> *In re* Indiana Fed. of Dentists, [1979-83 Transfer Binder] TRADE REG. REP. (CCH) ¶ 21,992 (Feb. 17, 1983) (final order to cease and desist). See also *In re* Texas Dental Ass'n, [1979-83 Transfer Binder] TRADE REG. REP. (CCH) ¶ 21,927 (Nov. 19, 1982) (consent order to cease and desist).

<sup>95</sup> See, e.g., *Arizona v. Maricopa County Med. Soc'y*, 102 S. Ct. 2466 (1982) (maximum fee setting by powerful professional organizations condemned); *Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002 (1982) (professional society's peer review committee to review charges for insurers not exempt under McCarran-Ferguson Act); *Peer Review Plan for Resolving Fee-Related Disputes*, 99 F.T.C. 648 (1982) (advisory opinion).

<sup>96</sup> See, e.g., Watson, *Disclosure of Computerized Health Care Information: Provider Privacy Rights Under Supply Side Competition*, 7 AM. J.L. & MED. 265 (1981); Part One, cases cited n. 65. See also JUDICIAL COUNCIL, *supra* note 8, at 16-18 (ethical principles governing confidentiality of computerized medical records).

<sup>97</sup> See generally J. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* (1977) (reviewing the design of the Medicare program); Havighurst, *supra* note 27, at 336-43 (reviewing professional influence over private insurance plans).

<sup>98</sup> On the treatment of cost issues as professional questions, see Havighurst & Blumstein, *supra* note 19; Havighurst, *supra* note 2. See also *supra* note 57.



in turn support, maintenance of its world view. Suppression of competition in the realm of ideas has been vital to the profession's economic success.

In sum, competition in the health services industry has been carefully prevented from focusing on the full range of matters that concern consumers. Profession-sponsored restraints on the range of options and information available, together with the exclusion of cost factors from medical decision making, have prevented the marketplace from usefully assisting in the efficient allocation of resources. Nevertheless, recent expansion of the supply of physicians and recent success in applying the antitrust laws to professional activities, particularly restraints on innovation in health care financing, have started an important process of competitive change in the direction of decentralizing decision making and turning market forces into reliable tools for allocating resources to health care uses.<sup>99</sup> One remaining area in which the antitrust laws have yet to be rigorously applied is the area of personnel credentialing. The preceding discussion should suggest that credentialing is more than merely a vehicle for communicating useful information to consumers and is thus a candidate for careful legal scrutiny.

## VI. UNRECOGNIZED ANTITRUST ISSUES IN PRIVATE CREDENTIALING

Although, as Part One shows, the antitrust laws properly provide only a limited remedy for unfair and deceptive credentialing practices, there are several other points at which the law might be invoked to improve the flow of information about health care personnel. To date, these issues have not arisen in litigation, and the complexity of the subject is such that it cannot be said with certainty that a factual basis exists for prosecuting each particular restraint tentatively identified here. Nevertheless, there appear to be a number of violations whose correction would contribute to innovative developments beneficial to consumers and to the breakdown of market power founded on professional ideology and consumer ignorance.

The antitrust problems investigated here are unusual and lack direct antecedents in decided cases. The uniqueness of these issues reflects the special role that information plays in health care markets and the unprecedented use by professional interests of control over information as a monopolizing tool. Despite the factual peculiarities thus introduced, the issues raised here seem amenable to analysis under the traditional rule of reason and by analogy to established precedent.

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<sup>99</sup> See generally MARKET REFORMS IN HEALTH CARE, *supra* note 2. On antitrust developments, see Havighurst, *The Contributions of Antitrust Law to a Procompetitive Health Care Policy*, in *id.* at 295.

## A. APPLYING THE RULE OF REASON

The antitrust rule of reason, though subject to much misunderstanding and misapplication, permits competitors to collaborate only when their actions are compatible with the maintenance of competition as the guarantor of consumer welfare. Despite occasional speculation and lower court holdings to the contrary,<sup>100</sup> this basic rule cannot be judicially varied for the health care industry or for professional competitors. To hold otherwise would be, in Judge William Howard Taft's classic words, "to set sail on a sea of doubt" and to rely on "the vague and varying opinion of judges as to how much, on principles of political economy, men ought to be allowed to restrain competition."<sup>101</sup> The Supreme Court has recently held that the usual per se rules of antitrust law do not have to be rejustified before applying them in the health care field.<sup>102</sup> The Court has also strongly indicated that the law requires competition, for better or for worse, even in professional fields.<sup>103</sup>

Although the actions of powerful professional groups must be analyzed for antitrust purposes only to determine their effects on competition, the health care marketplace has certain peculiarities that can complicate this analysis. In particular, consumer ignorance and uncertainty and the compensating role of knowledgeable, risk-spreading intermediaries are factors that must be appreciated by antitrust analysts, who are accustomed to thinking only in terms of simple products and two-party transactions. As the Supreme Court has stated, "professional services may differ significantly from other business services, and accordingly, the nature of competition in such services may vary."<sup>104</sup> Although this statement has usually been read as suggesting a go-slow, tolerant approach, it may also be read as a reminder that the threats to competition posed by professional

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<sup>100</sup> See, e.g., *Wilk v. AMA*, 719 F.2d 207 (7th Cir. 1983); *Arizona v. Maricopa County Med. Soc'y*, 643 F.2d 553 (9th Cir. 1980), *rev'd*, 102 S. Ct. 2466 (1982); *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 691 F.2d 678 (4th Cir. 1982), *cert. denied*, 52 U.S.L.W. 3280 (U.S. Oct. 11, 1983); Norris & Szabo, *Communication Between the Antitrust and the Health Law Bars: Appeals for More Effective Dialogue and a New Rule of Reason*, 7 AM. J.L. & MED. i (1981); Pfizenmayer, *Antitrust Law and Collective Physician Negotiations with Third Parties: The Relative Value Guide Object Lesson*, 7 J. HEALTH POL., POL'Y & L. 128 (1982). On the *Rex* case, see Havighurst, *Health Planning and Antitrust Law: The Implied Amendment Doctrine of the Rex Hospital Case*, N.C. CENT. L.J. (in press).

<sup>101</sup> *United States v. Addyston Pipe and Steel Co.*, 85 F. 271, 283-84 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899).

<sup>102</sup> *Arizona v. Maricopa County Med. Soc'y*, 102 S. Ct. 2466, 2476 (1982).

<sup>103</sup> *National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679, 695-96 (1978). *But see infra* note 108; *Wilk v. AMA*, 719 F.2d 207 (7th Cir. 1983) (criticized *supra* note 79 and accompanying text).

<sup>104</sup> 435 U.S. at 696. Defendants were not permitted to offer proof to the effect that by discouraging cut-rate engineering work dangerous to public health and safety their ethical prohibition of competitive bidding benefitted consumers more than price competition.

activities may differ from the restraints typically found in industrial markets. Enforcement agencies and courts must be alert to recognize these special hazards.

In the recent *Maricopa County Medical Society* case,<sup>105</sup> the Supreme Court, by a narrow 4-3 margin, resisted the temptation to tolerate anticompetitive practices that were arguably beneficial to consumers, at least in the short run. By holding professional agreements on maximum fees unlawful without listening to evidence that prices were actually lowered, the Court scotched the notion that dominant professional organizations rather than market forces are responsible for controlling the cost of medical care. Though ostensibly rejecting the rule of reason and applying the usual *per se* rule against price fixing, the majority did not apply the *per se* rule blindly without considering its appropriateness in the new factual context. Instead, it exercised "reason" to satisfy itself that the practices in question were not likely to be procompetitive and that they threatened desirable competition.<sup>106</sup> As part of his analysis, Justice Stevens observed that competitively inspired arrangements could solve the problems to which the profession-sponsored price controls were ostensibly addressed.<sup>107</sup>

Single-minded judicial insistence on competition in health care would not preclude all competitor collaboration. Legitimate "procompetitive" purposes, to which competitor-sponsored restraints must be "ancillary" if they are to be upheld, include the pursuit of production efficiency and the offering of distinct products or services. It is not enough that the purpose be worthy;<sup>108</sup> it must also be entrepreneurial in nature—a business

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<sup>105</sup> 102 S. Ct. 2466 (1982).

<sup>106</sup> *Id.* at 2477. The decision can be criticized for not making the power of the organization an explicit element of the offense found, since arrangements that are arguably efficient should not be foreclosed unless the percentage of competitors involved is dangerously and unnecessarily large or so large as to alter the probability of net procompetitive effects. *See infra* note 109. The Court also relied unnecessarily on three highly troublesome prior decisions: *United States v. Topco Assocs.*, 405 U.S. 596 (1972) (joint venture of modest size held guilty of the *per se* offense of market division despite a high probability of efficiency); *Albrecht v. Herald Co.*, 390 U.S. 145 (1968) (vertical imposition of maximum resale price equated with fixing minimum price despite clear benefit to consumers); *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211 (1951) (similar). *See* Gerhart, *The Supreme Court and Antitrust Analysis: The (Near) Triumph of the Chicago School*, 1982 Sup. Ct. Rev. 319. Despite these questionable features of the opinion, the *Maricopa* result is defensible on the ground that the defendant physician organizations possessed substantial market power, were likely to preclude or inhibit competitive innovation, and offered no obvious efficiencies not obtainable by organizing on a lesser scale. *See supra* note 57. *Cf.* Havighurst & Hackbarth, *supra* note 57.

<sup>107</sup> 102 S. Ct. at 2477-78. The Court referred specifically to the contractual agreements between insurers and providers that were at issue in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *See supra* note 30.

<sup>108</sup> Existing doctrine may leave room for a very narrow "worthy purpose" defense based on a claim that, although an agreement eliminates some competition, it overcomes a market failure and thus leads to results closer to those that would be yielded if the market functioned smoothly. *See* Part One, n. 124; *supra* note 51. *See also* P. AREEDA, *THE "RULE OF REASON" IN*

purpose—and one that is realizable whether or not the collaborators collectively possess market power. Proof of such a procompetitive purpose does not end the matter, however, for it is also essential that the actions taken not have destructive effects on the competitive process that outweigh the anticipated benefits. The danger of such destructive effects arises only when facts such as the combined market share of the competitor group indicate that market power is present.<sup>109</sup> Broadly based professional associations probably possess enough market power that the risks to competition posed by their activities must be balanced against the expected benefits. On the other hand, nondominant organizations—a small group practice, for example—should be free from antitrust scrutiny altogether.<sup>110</sup>

Because private certification, accreditation, and seal-of-approval programs generate new information, they are presumptively procompetitive. Nevertheless, credentialing is typically carried out by dominant professional organizations and is thus subject to scrutiny for anticompetitive tendencies. One way that a credentialing body might harm competition is by unfairly impairing some competitors' market opportunities; Part One shows that limited scrutiny, but no more than limited scrutiny, is appropriate in appraising claims of injury of this type—that is, claims of unfairness and deception. Credentialing bodies may also, however, take actions that do more than arguably harm competitors—actions that frustrate the operation of the competitive process itself. It is restraints of this variety that are

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ANTITRUST ANALYSIS: GENERAL ISSUES 5-8 (1981). Although the defense explicitly rejected in *National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679 (1978), see *supra* note 104, took essentially this form, the restraint in that case was very broad and affected price rather than non-price competition; moreover, the Court found the market-failure claim implausible because most buyers were not unsophisticated. In contrast to the engineers' "frontal assault on the basic policy of Sherman Act," *id.* at 695, the narrow market-failure defense suggested here may have the merit that, while respecting the competitive paradigm, it averts the charge of mindlessness that, in view of the undeniable imperfections in real-world markets, could be leveled against the absolutist view which holds that the law requires competition for better or for worse. In any event, it would seem that a theory which permitted occasional balancing of potential benefits and harms in light of a strong presumption favoring competition would seldom result in approval of a naked restraint. Thus, while Areeda suggests one hypothetical restraint that might be approved, AREEDA, *supra*, at 4, 7-8, he also presents others that, while arguable, would seem not to warrant an exception. P. AREEDA, ANTITRUST ANALYSIS ¶¶ 346, 348-49, 351, 380 (3d ed. 1981). None of the restraints examined in the remainder of this Article would seem defensible under a market-failure theory. But see *supra* note 51.

<sup>109</sup> See generally Landes & Posner, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937 (1981). The authors note "a growing authority for requiring proof of substantial market power in a § 1 Rule of Reason case." *Id.* at 956 n.35. In a joint venture case under section 1, power should be a factor in deciding whether particular conduct, not amounting to a naked restraint condemnable under a per se rule, should be subject to additional scrutiny and possibly to a requirement that the purpose being pursued, while legitimate, must be achieved by a less restrictive alternative means—such as by organizing on a smaller scale. See *supra* note 106.

<sup>110</sup> For one attempt to state a rule of thumb distinguishing joint ventures with excessive power from those that are deemed procompetitive on balance, see FTC, *supra* note 91, 46 Fed. Reg. at 48,988-912.

the subject of discussion here. Courts should closely examine the behavior of powerful competitor groups operating credentialing programs to ensure that they are doing no more than furnishing procompetitive information or opinion and are not conspiring or combining to eliminate competition in health services or in the provision of information.

Antitrust attention focuses most naturally on how the practices of competitor groups affect the markets in which those competitors compete. Another helpful way of analyzing the information problems of the health care sector, however, is to focus not on the market for services but on *the market for information itself*. Even though information concerning the attributes of health care providers is seldom sold to consumers in market transactions (because it is a public good), its production can easily be seen to constitute "trade or commerce" within the meaning of the Sherman Act. Not only do consumers value such information highly as an aid in making wiser purchases of vital services, but providers of such services attach such value to it that they willingly absorb the cost of its production and dissemination, either by paying dues to the certifying organization or by paying application fees. In this sense credentialing information is indeed bought and sold, and it should now be clear how important it is that its production not be monopolized. Much of the antitrust agenda set forth below contemplates recognition of the market for information as a discrete relevant market in which to look for restraints of trade.<sup>111</sup>

Under the view that the production of data and opinion informing market decisions is "trade" that should not be restrained,<sup>112</sup> entities en-

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<sup>111</sup> Although it is not customary to define a "relevant market" in section 1 cases, mistakes can occur when the affected market is not carefully identified. *E.g.*, *Chicago Bd. of Trade v. United States*, 246 U.S. 231 (1918) (focusing on market for grain or "to-arrive" grain, when the market actually restrained was for middleman services in the buying and selling of grain); *Standard Oil Co. (Indiana) v. United States*, 283 U.S. 163 (1931) (focusing on market for gasoline or "cracked" gasoline, when the market actually restrained was for patented cracking technology). On defining the relevant market in a merger context, see *infra* notes 144-45 and accompanying text; see also *infra* notes 159-62 and accompanying text.

<sup>112</sup> In a report criticized in Part One, text accompanying nn. 154-59, the FTC staff took the dubious position that, because competitor-sponsored standards influence consumer choices, they "restrain trade" and are unlawful if a "less restrictive alternative" (i.e., a better standard) is available. FTC, *STAFF REPORT, STANDARDS AND CERTIFICATION* 244-61 (1983) [hereinafter cited as *FTC STAFF REPORT*]. This analysis of joint ventures to produce commercial information is faulty because it fails to recognize that such information, though produced solely because of its value in other markets, is independent of the goods and services whose purchase it informs and thus constitutes a separate product market. The procompetitive virtues of such joint ventures can be more satisfactorily assessed in their own market than in the market in which they affect demand. Indeed, the FTC staff's approach to the collective production of information implies that a joint venture to produce, for example, a mainframe computer should be scrutinized primarily for effects, not in the computer market, but in the complementary market for peripheral equipment. Although such effects are relevant, see *infra* note 114, exclusive focus on them invites close assessment of the quality of the particular information generated (the approach criticized in Part One) and loses sight altogether of anticompetitive effects in the information market.

gaged in or potentially engaged in producing such information are competitors whose agreements with each other are subject to scrutiny under the Sherman Act.<sup>113</sup> In carrying out antitrust analysis under this theory, one should be alert to discover agreements among such competitors that restrict entry into the business of producing information, that limit the kinds of information that will be produced, or that foreclose competition in that market altogether. Even if one prefers to conclude that it is the effect in the market for services that matters most, restraints on the supply of information are appropriate targets for antitrust enforcement.<sup>114</sup>

The discussion now turns to a series of specific practices and arrangements by entities engaged in personnel credentialing and institutional accrediting in the health care field that appear vulnerable to antitrust attack. It is submitted that efforts to remedy these abuses would increase the quantity and quality of useful information available to consumers and thus improve the overall functioning of markets for health care services.

#### B. GRANDFATHERING

A special problem is presented by the practice of periodically raising certification standards for new applicants without requiring incumbents in the field to demonstrate their own ability to meet such higher standards.

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<sup>113</sup> Under this view, voluntary nonprofit associations, both competitor-controlled and independent, that deal only in information are engaged in trade. In *American Soc'y of Mech. Eng'rs v. Hydrolevel Corp.*, 102 S. Ct. 1935, 1947 (1982), the Supreme Court refused to exempt petitioner ASME from vicarious antitrust liability because "[a]lthough ASME may not operate for profit, it does derive benefits from its codes, including the fees the Society receives for its code-related publications and services, the prestige the codes bring to the Society, the influence they permit ASME to wield, and the aid the standards provide the profession . . ." Similarly, in *Roofire Alarm Co. v. Underwriters Labs.*, 188 F. Supp. 753, 754 (E.D. Tenn. 1959), *aff'd*, 284 F.2d 360 (6th Cir. 1960), defendant Underwriters Laboratories (UL) was described as "a business league formed to perform services ordinarily conducted for profit. It is clearly not established for public welfare, but for private gain . . . to benefit qualifying manufacturers and insurance companies . . . through reduced fire losses." This common-law case was followed by an antitrust case finding UL's failure to certify plaintiff's fire alarm reasonable under the Sherman Act. *Roofire Alarm Co. v. Royal Indem. Co.* 202 F. Supp. 166 (E.D. Tenn. 1962), *aff'd*, 313 F.2d 635 (6th Cir.), *cert. denied*, 373 U.S. 949 (1963). Although the Sherman Act would appear to apply to nonprofit certifiers and accreditors, the FTC would probably lack jurisdiction over any that were not competitor-controlled. See Part One, nn. 184-85 and accompanying text.

<sup>114</sup> Even if the production of commercially valuable information does not itself constitute trade or commerce, collective action restraining it may be unlawful if the market for services is adversely affected. *Cf. McLain v. Real Estate Bd. of New Orleans*, 444 U.S. 232, 241 (1980) (stating that the Sherman Act, like the Commerce Clause, "has . . . long been interpreted to extend beyond activities actually in interstate commerce to reach other activities that, while wholly local in nature, nevertheless substantially affect interstate commerce"); *AMA v. United States*, 317 U.S. 519, 528 (1942) (declining to reach the issue of whether a physician's practice constitutes "trade" under the Sherman Act, since "the calling or occupation of the individual physicians charged as defendants is immaterial if the purpose and effect of their conspiracy" was to impose restraints proscribed by the antitrust laws).

Though ostensibly aimed at improving the quality of care, such grandfathering may also reflect anticompetitive impulses. For example, certificate holders operating a certification program may succumb to the temptation to lengthen the required period of training simply in order to increase the capital investment (including earnings forgone during training) that an aspirant must make before entering the field. Because raising the cost of entry necessarily reduces the number of practitioners entering the field, prices will be higher than they otherwise would be, yielding more than a competitive return to incumbents, who do not have to make comparable new investments.<sup>115</sup> A similar effect on entry could also be obtained by permitting a lower percentage of aspirants to pass certification exams.<sup>116</sup>

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<sup>115</sup> This effect is concisely spelled out in P. FELDSTEIN, *supra* note 11, at 324-25 (footnote omitted):

The third method used by the medical profession to restrict entry, which is also meant to increase the competence of the new physician, is to lengthen the training time required for the student to become a practicing physician . . . . The effect of continually increasing the training required before entering a profession is to raise the costs to the entering student. Not only are tuition costs higher the longer the requirements for undergraduate and medical school education are, but more importantly, the income foregone because of the additional years of training is very large. These increased costs reduce the rate of return to someone entering the medical profession. The emphasis in terms of quality is always on the entering physician and not on those currently in the profession. It is in the economic interests of current practitioners that the costs of entering the profession continually increase; since their training occurred in the past at a lower cost, they will receive higher prices and higher incomes in the form of economic rent.

If the market for physician services were a competitive one, then the more highly trained physicians could advertise their increased training and more recent knowledge and receive a higher price for their services than physicians without this additional training. In such a competitive situation there would be little economic incentive for current physicians to promote higher training requirements for new physicians; therefore, to prevent new physicians from receiving higher returns than current physicians with less training do, it is necessary for the medical profession to maintain the fiction that *all* physicians are of uniform quality. To enforce this impression among patients, the medical profession discourages any intraprofessional criticism and prohibits the advertisement of differences in training or any other quality differentials among physicians. . . . This third barrier to entry, which takes the form of continual increases in the training costs for entering physicians, suggests that measures to increase the quality of physician services are independent of demands by consumers for increased quality and instead are related to the income considerations of the medical profession.

<sup>116</sup> In *Ronwin v. State Bar of Ariz.*, 686 F.2d 692 (9th Cir. 1982), *cert. granted*, 51 U.S.L.W. 3825 (U.S. May 16, 1983) (No. 82-1474), plaintiff claimed that the state bar controlled the number of new entrants by manipulating the pass rate on the state licensure examination. Comparable manipulation of pass rates on certification exams would be a less effective strategy because persons failing the exam would not be legally barred from competing and, having had the same training as certificate holders, could do so quite effectively. Specialty certifiers will therefore prefer to lengthen training, since that strategy discourages potential entrants from embarking on training in the first place and produces fewer uncertified competitors. In fact, the passing rate on most specialty certification examinations is fairly constant from year to year.

The imposition of more demanding requirements on new applicants alone cannot be defended as procompetitive behavior. As information, certification is less valuable to consumers and other users—and indeed could be dangerously misleading—if there is in fact a wide variation in attainments among certificate holders. More significantly, the benefits of grandfathering to incumbents in the field do not result simply from the provision of information and the rectification of consumer information problems in markets for professional services. Instead, because grandfathering owes its effectiveness to the absence of alternative information sources that can help consumers differentiate among practitioners having different levels of skill, it is actually a way of exploiting market imperfections for the benefit of established practitioners. Thus, if certification signifying lower (but still substantial) levels of achievement were available, new entrants in the specialty would not be forced to accept the new requirements in order to obtain any recognition at all for their specialized skills. Similarly, if competitors with greater training could easily differentiate themselves from those certified under less rigorous standards, incumbents would not be able to raise requirements for new entrants without harm to themselves. These observations should suggest to antitrust enforcers and courts that credentialing schemes are not automatically procompetitive and may frequently serve to perpetuate rather than to break down market power attributable to information problems. Indeed, given their sponsorship by organized professional interests, there is good reason to suspect that the true purpose of credentialing programs with provision for grandfathering is to diminish rather than to improve the ability of consumers to detect differences among available practitioners.

It may be argued that an increase in training requirements does no more than express the certifiers' view that longer training is required to bring new entrants up to the standards that incumbents have already achieved through experience.<sup>117</sup> Such a characterization of the new standards would not, however, bring the discriminatory requirements within that area where, under the analysis in Part One, antitrust courts should engage in only limited scrutiny. This is not a case where some competitors seek simply to differentiate themselves from others. Instead, a credentialing system based on grandfathering is dedicated to keeping all competitors, including many less qualified ones, under the same umbrella. It is thus another manifestation of the profession's desire to prevent differentiation of subsets of practitioners within a competing group. It is relevant for

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<sup>117</sup> Kissam would presumably so argue. See Kissam, *Applying Antitrust Law to Medical Credentialing*, 7 AM. J.L. & MED. 1, 17-19 (1981); Kissam, *supra* note 76 at 11, 46-48 (arguing generally that credentialing and accrediting standards are expressions of professional opinion deserving significant protection from antitrust enforcement).



antitrust purposes that grandfathering maintains the inclusiveness, and thus the market power, of the credentialed group and reduces rather than improves the ability of consumers to differentiate among competitors. The argument in Part One against close scrutiny of standard setting, certification, and accreditation was explicitly based on the procompetitive value of any program that distinguishes among competing practitioners. A corollary is that a practice obviously obscuring differences is not procompetitive.

Even though competitor-sponsored certification standards that substantially discriminate against new entrants should be found unlawful, a fairly liberal rule of reason should be applied when a certifying body has made a good faith effort to devise recertification requirements that are comparable in rigor to the requirements imposed on new applicants.<sup>118</sup> Nevertheless, a recertification program would seem unconvincing as a compensation for raising the requirements for new entry unless it resulted in the decertification of a significant number of those certified under the earlier standard. Failing that, the certifiers should have to demonstrate the equivalency of certification and recertification requirements. Equivalency might be sought, for example, by having incumbents submit records of their actual practice experience—number of cases by category, success rates, and so forth—and by requiring continuing education and documented learning to fill specific gaps. However, it remains difficult to imagine an evenhanded credentialing system in which rising standards would not leave a substantial number of competitors behind.<sup>119</sup>

Grandfathering can perhaps be best defended by claiming that certification is in fact only a one-time thing, signifying only that the individual was, at one time, abreast of the state of the art in his field of specialization. Such an argument cannot be dismissed out of hand, because such information is of positive value and most users of it could be expected to appreciate the difference between certifications granted in, say, 1963 and 1983. Nevertheless, any attempt to excuse grandfathering as practiced by medical specialty boards by characterizing certification in these innocuous terms is likely to fail. For one thing, it is inconsistent with general usage in the

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<sup>118</sup> Certification and recertification requirements need not be identical, of course. Because those engaged in clinical practice may not keep current in the entire field but achieve unusual expertise in their area of actual practice, recertification might depend upon a showing of specific rather than general competence. Also, the availability of outcome data suggests that clinical skills can be evaluated directly rather than solely by examination. See discussion *infra* notes 151-52.

<sup>119</sup> Currently available literature indicates that only the most exemplary candidates seek voluntary recertification, and, of those who do, the youngest and most academically-oriented perform best on recertification examinations, See, e.g., Cruft, *et al.*, *Recertification in Surgery 1980*, 116 ARCH. SURG. 1093 (1981); Meskauskas & Webster, *The American Board of Internal Medicine Recertification Examination: Process and Results*, 82 ANN. INTERN. MED. 577 (1975). This evidence strongly suggests that those certified under less rigorous standards do not necessarily keep up with the state of the art.

profession, which says that a physician *is* (not *was*) board-certified, and with numerous representations implying that certification has continuing significance. Perhaps a specialty board could legitimize its grandfathering practices, however, by adopting a system of "vintaging" under which certificate holders would have to disclose the date of their certification in all official statements and advertising.<sup>120</sup> Absent some such measure to overcome the inference of current skill naturally drawn from certification, grandfathering must be viewed as a suspect practice whose anticompetitive impact outweighs any procompetitive informational value in setting specialists apart from other physicians.<sup>121</sup>

The problem that grandfathering solves for the medical profession is that of accommodating changes in the state of the art within an area of practice. If training requirements were not raised periodically to reflect technological developments, practitioners whose experience put them well ahead of those newly entering the specialty would have strong motives to seek a different set of credentials. Any move on their part to differentiate themselves would split the profession and open up new possibilities for competition. Similar fragmenting effects would occur if the certifiers chose instead to raise standards for all, because those practitioners who were dropped from the rolls for not keeping up would still remain as effective fringe competitors (and potential price cutters), at least in the less demanding areas of specialty practice. Grandfathering obviously provides a felici-

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<sup>120</sup> Under a vintaging system, "certified since 1963" would be a misleading claim unless it meant that initial certification was followed by periodic recertification up to the present; for a single certification only, "certified *in* 1963" would be the acceptable designation.

The ABMS now permits specialty boards to adopt a kind of vintaging policy. The listing of specialists in its Directory of Medical Specialties will include the date of original certification and the dates of any recertifications, "[a]t the request of the Member Board and unless permission is denied by the diplomate." ABMS, ANNUAL REPORT AND REFERENCE HANDBOOK—1982 54.

<sup>121</sup> In common-law cases involving challenges to grandfather clauses as unfair to new applicants, the clauses have been found permissible under minimal scrutiny. See *Kreuzer v. American Academy of Periodontology*, 558 F. Supp. 683, 685 (D.D.C. 1983); *Dietz v. American Dental Ass'n*, 479 F. Supp. 554, 560-61 (E.D. Mich. 1979). See also *Pinsker v. Pacific Coast Soc'y of Orthodontists*, 12 Cal. 3d 541, 560, 526 P.2d 253, 267, 116 Cal. Rptr. 245, 259 (1974), where a dentist who could have joined an orthodontic society pursuant to a grandfather clause but had not was found currently unqualified to perform services limited to members because of the validity of the grandfather clause and because "defendants could properly conclude that through participation in the association's numerous activities, society members have been exposed to new professional developments not generally available to nonmembers." These cases rely on *Watson v. Maryland*, 218 U.S. 173 (1910), which upheld a grandfather clause in a statutory physician licensure scheme against an equal protection challenge, holding that the state in its exercise of the police power might reasonably conclude that persons already in practice possessed skills equivalent to those which others were required to demonstrate. Although such a finding would be consistent with the minimal scrutiny of standards on fairness grounds that was advocated in Part One, the effect of a grandfather clause on competition is a distinct issue. See *supra* text accompanying note 117.

tous solution to the profession's dilemma by letting all credential holders retain their exalted status, whether currently deserved or undeserved. From an antitrust standpoint, however, the strategy can only be regarded as a monopolistic effort to maintain professional solidarity, to restrain competitive forces, to suppress information, and to preserve the misleading appearance of homogeneity in professional ranks. Antitrust law should recognize a fundamental distinction between credentialing that differentiates among competitors—perhaps even unfairly—and a credentialing scheme that is designed in such a way as to obscure any differences that do exist.

From the standpoint of antitrust doctrine, it would be difficult to attack grandfathering as a part of a larger conspiracy to withhold information from consumers. Though intellectually appealing, such a legal theory would find little support in precedent and would require factual proof of anticompetitive purpose or effect that could not be easily obtained. Accordingly, the easiest way to challenge suspicious increases in certification standards under the antitrust laws would be to allege a conspiracy to raise entry barriers and limit supply. Credentialing requirements are obviously not illegal, however, simply because they constitute an entry barrier. It would therefore also be necessary to allege and show cost-increasing discrimination in the application of standards between incumbents and would-be entrants.

Although fairness to new applicants would seem to be the focal point of a case brought under such a theory, the antitrust laws, properly understood, are not primarily concerned with fairness, but with consumer welfare.<sup>122</sup> But there is little doubt that consumers are harmed when competitors take collective action that imposes on new entrants costs that incumbents do not themselves have to incur.<sup>123</sup> Where concerted action by competitors has this effect, it is not necessary to show a crass or anticompetitive motive. It is enough that competition is harmed. For this reason, the good faith of the credentialers, who may sincerely believe that they are serving the public by raising quality standards, would be no defense to an antitrust charge.

The requisite injury to competition should not be difficult to show. Indeed, a group of specialists using the technique of regularly increasing certification requirements might be able to limit indefinitely the supply of practitioners in the specialty. Moreover, the adoption of increasingly burdensome requirements in all specialties would raise entry costs for everyone aspiring to practice medicine on a respectable level. Although competition from uncertified physicians could eventually become a sig-

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<sup>122</sup> See Part One, n. 128.

<sup>123</sup> See *supra* note 115.

nificant check on certified specialists' exercise of market power,<sup>124</sup> those entrenched behind rising entry barriers can still expect to maintain their incomes at high levels. Even if one should accept the view that certification constitutes a one-time (rather than a continuing) recognition of distinction, the periodic raising of requirements in a context where certification is a virtual prerequisite to successful practice would seem harmful enough to competition to outweigh the claim that such information has procompetitive value.

It is legally insufficient to object to the rigor of the antitrust rule suggested here on the ground that it would discourage a certifying body—a specialty board, for example—from upgrading the quality of care.<sup>125</sup> In a competitive health care industry, it is not the province of a single competitor group to set the minimum quality standards for entry into the field, and the credentialers' good faith and good intentions are no defense to an antitrust charge, which is aimed at maintaining competitive conditions, not at punishing antisocial behavior. Antitrust law is appropriately invoked to confine credentialing systems to the performance of the procompetitive task of providing information useful in differentiating among practitioners. With grandfathering, credentialing makes too small a contribution to informing the public to ignore either its obvious effect—raising entry costs—or its less obvious effects—limiting the supply of information about differences among competing specialists and discouraging competitive behavior within the specialists' ranks.

Once the antitrust rule suggested here is recognized as valid, desirable changes can follow. Curtailment of a certifying entity's power to resolve conflicts among competitors in the field—a power crucial to the success of any cartel—would unleash pressures of precisely the kinds that are needed to stimulate procompetitive changes in credentialing. One possibility is that competitor-controlled credentialing bodies, barred from raising standards

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<sup>124</sup> As the costs of mandated education rise, individual physicians might get off the certification track and enter specialized practice with less than the prescribed amount of training. Competing group practices or HMOs might undertake to provide unaccredited training as a way of providing specialized services at lower cost. It thus appears that the strategy of raising standards may not be pressed beyond a certain point and may become less effective as the system becomes more cost conscious and less monolithic, offering opportunities to competent but uncertified specialists who are willing to work for less than their more expensively trained competitors.

<sup>125</sup> A recent official AMA statement expressly recognizes that the purpose of certification extends beyond providing information useful to consumers and includes also "the intent of each specialty board to raise its standards continually, as applied to both the education and assessment of candidates, so that the quality of medical practice will continue to rise steadily." AMA, *82nd Annual Report on Medical Education in the United States 1981-82*, 248 J. A.M.A. 3225, 3233 (1982). See P. FELDSTEIN, *supra* note 11.

only for new entrants, would maintain existing standards indefinitely. As those standards became increasingly obsolete with changes in the state of the art, pressures to create new certification programs would increase, and competition in credentialing could be expected to ensue. A new credentialing body established by the most highly skilled competitors would be free to set its own quality-related standards as long as there was no obvious deception or discrimination in favor of established practitioners.

Another possibility is that, faced with antitrust risks in grandfathering, existing credentialing bodies would adopt meaningful recertification requirements. The informational advantages of this approach are obvious. In addition, it would almost certainly create a new class of decertified practitioners who could still compete effectively in providing many services, perhaps at lower prices. Over time, one might expect other devices to arise whereby even these practitioners could differentiate themselves. For example, specialties might develop within specialties, allowing some of these practitioners to carve out niches for themselves instead of accepting roles assigned by their competitors. In the long run, higher-priced specialists would face meaningful competition from lower-priced ones, at least in the provision of less demanding services. In due course, the market rather than organized medicine would determine the appropriate levels of training for providing various services and would assign tasks on a more efficient basis, letting the less qualified practitioners perform the functions for which they were best suited.

Life in a world conducive to competition in credentialing would undoubtedly be different from life in the world we know. Predictions of catastrophe resulting from enforcement of the antitrust rules derived in this analysis can be expected, but they are no less speculative—indeed, are probably more so—than the scenarios sketched above. In any event, although it is always fair to ask whether consumers would benefit from enforcing the rules of free enterprise in a particular context, that question is not relevant in antitrust analysis, which considers only whether competition is helped or hurt, not whether it is good or bad. Intuition nevertheless strongly suggests in this instance that most of the changes that would follow enforcement of antitrust rules in the medical care marketplace would be beneficial to consumers. Moreover, our political and economic heritage supplies powerful and well supported presumptions in favor both of letting citizens choose for themselves and of fostering their access to information useful in making informed choices. It seems clear that the tactic of grandfathering incumbents, whenever credentialing standards are introduced or changed, has been employed by professional interests, not to facilitate informed consumer choice, but as a vital part of a larger monopolistic strategy for curbing choice.

## C. STANDARDIZATION

Earlier discussion reviewed how the medical profession has worked aggressively to standardize health care personnel as part of a larger effort to standardize medical care, thereby preempting decision-making powers that might otherwise be assumed by consumers and their agents. The profession's standardization efforts have been quite similar to strategies followed by industrial cartels, which have had to agree on the precise character of their products in order to fix prices. Although it would be stretching a bit to characterize the profession's goal as price fixing,<sup>126</sup> a major objective of physicians in pursuing standardization has been to attenuate competitive forces. Moreover, the price-increasing consequences of their actions have been similar to and substantially more durable than the results achieved by industrial price fixers.

The antitrust principles governing industrial standard setting are frequently thought to be unclear,<sup>127</sup> but the conceptual framework for legally assessing standardization efforts of all kinds is really quite straightforward. A standardization program must be analyzed to see whether it involves simply labeling certain products as conforming to standards or instead goes further, crossing the line that separates supplying information from impermissible private regulation. Personnel certification in the health care industry appears for the most part to fall well on the safe side of this line. As shown earlier, programs that assist consumers and others in differentiating among competing products or service providers are presumptively procompetitive and are appropriately subject to no more than limited judicial scrutiny. On the other hand, an agreement to boycott uncertified personnel would be unlawful.<sup>128</sup> Likewise, a standardization program that amounted to an affirmative agreement by producers to limit production of nonstandard products should also be illegal as a naked agreement not to compete.<sup>129</sup> There is a crucial distinction—much easier to state conceptually

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<sup>126</sup> See *supra* notes 24-32 and accompanying text.

<sup>127</sup> FTC STAFF REPORT, *supra* note 112, at 242-79; Curran, *Industrial Standards, Antitrust, and the Logic of Public Action: An Historical Search for a Rational Policy*, 17 DUQ. L. REV. 717 (1979).

<sup>128</sup> See Part One, text accompanying nn. 141-50.

<sup>129</sup> In *National Macaroni Mfrs. Ass'n v. FTC*, 65 F.T.C. 583 (1964), *aff'd*, 345 F.2d 421 (7th Cir. 1965), defendants had agreed to reduce the proportion of durum wheat in macaroni in order to depress the price of that component in a time of short supply. The Commission prohibited using standardization "for the purpose of fixing or manipulating the price of such ingredients." 65 F.T.C. at 612. Agreements to standardize products might also be condemned in a particular case as a technique for facilitating oligopolistic conduct. See *supra* note 26. But because the benefits of standardization can be achieved by means less restrictive than industrywide agreements not to produce nonstandard products, such naked agreements not to compete should be unlawful without proof of their purpose or effect. The FTC's statement in the *Macaroni* case that "[w]e do not hold that all efforts at product standardization . . . are unlawful," 65 F.T.C. at 612, should not be read as recognizing no legal difference between specifying standards and affirmatively agreeing to produce only standard items.

ally than to draw in practice—between competitor collaboration to publish useful information and a horizontal agreement, express or implied, by which competitors finally surrender their independent judgment about what goods or services they will buy or sell.

Because certifying bodies do not themselves produce the personnel whom their credentials tend to standardize, they cannot be accused of agreeing not to produce nonconforming models. Educational institutions collectively participating in an educational accreditation program run some legal risks, however. The crucial issue is the entirely factual question whether they have retained their freedom to act in nonconforming ways. Simply participating in the setting of accreditation standards would not give rise to an automatic inference of an agreement not to depart from the agreed-upon standards.<sup>130</sup> Moreover, if some of the participating institutions in fact operated unaccredited programs in addition to their accredited ones, the existence of an agreement to confine their competitive efforts would be effectively negated. On the other hand, unanimous compliance with accrediting standards would be a suspicious circumstance, and inquiry into the reasons for such “conscious parallelism” would be necessary to see how probative it might be as circumstantial evidence of a conspiracy.<sup>131</sup>

In any case involving industry-wide adherence to some common practice or to a set of competition-limiting standards, the essential factual question is whether the individual competitors have good reasons of their own, unrelated to what their competitors are doing, for adhering to that practice or those standards.<sup>132</sup> Thus, if it does not appear that individual

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<sup>130</sup> Conspiracies among educational institutions to limit students' range of choice are not unprecedented. It has been alleged, with apparent good cause, that, in the early part of the century, leading American law schools used accreditation to justify (and coordinate) an increase in their respective courses of study from two to three years. See First, *Competition in the Legal Education Industry (II): An Antitrust Analysis*, 54 N.Y.U. L. REV. 1049, 1077-78 (1979) (hereinafter cited as First II); First, *Competition in the Legal Education Industry (I)*, 53 N.Y.U. L. REV. 311, 336-38 (1978) (hereinafter cited as First I). A similar agreement today should not be excused simply because an accreditation program provided the vehicle for agreement and enforcement.

<sup>131</sup> See, e.g., *Theatre Enters. v. Paramount Film Dist. Corp.*, 346 U.S. 537 (1954); *Interstate Circuit, Inc. v. United States*, 306 U.S. 208 (1939). See also Posner, *Oligopoly and the Antitrust Laws: A Suggested Approach*, 21 STAN. L. REV. 1562 (1969); Turner, *The Definition of Agreement under the Sherman Act: Conscious Parallelism and Refusal to Deal*, 75 HARV. L. REV. 655 (1962).

<sup>132</sup> Conscious parallelism may result from oligopolistic interdependence rather than from explicit collusion, but may still be unlawful. *Interstate Circuit Inc. v. United States*, 306 U.S. at 222. The key to inferring an actual or tacit conspiracy is generally recognized to be a finding that the parallel actions would be contrary to the self interest of each individual actor unless all of them acted in the same fashion. See *Bogosian v. Gulf Oil Corp.*, 561 F.2d 434 (3d Cir. 1977), cert. denied, 434 U.S. 1086 (1978); *Ambook Enters. v. Time, Inc.*, 612 F.2d 604 (2d Cir. 1979), cert. dismissed, 448 U.S. 914 (1980).

firms are foregoing lucrative market opportunities, then no conspiracy, nor even independent mutual forbearance from such competitive initiatives, can be inferred. In the medical training context, if no direct evidence of conspiracy appears, teaching institutions could explain the unanimity of compliance with current accrediting standards on the basis that, because of the requirements of specialty certification, there is little demand for unaccredited training. By the same token, however, if the dominance of a particular certification system should begin to break down and if aspirants to practice in a particular field began to have a need for unaccredited training, continued unanimity in refusing to provide such training could be the subject of a successful conspiracy charge. Because the analysis in this Article contemplates developments that would ultimately increase demand for training different from that prescribed by professional standards, educational institutions must be careful not to fall into a pattern of undeviating and unthinking adherence to standards that, under new market conditions, would expose them to antitrust risks.

It is notable that it would not be a complete defense to a conspiracy charge that educational institutions adhered to standards because they feared loss of accreditation. Although the absence of demand for unaccredited training is a defense, the decision whether to offer such training should not be influenced by a sanction that exceeds in severity that which the market imposes. Thus, if a competitor-sponsored accrediting program should threaten to disaccredit an entire institution if it should offer a single unapproved training program, that threat would be powerful proof that the accrediting program was in reality a conspiracy to compete only in agreed-upon ways. It is of considerable interest, then, that in the health care field some educational accreditation programs accredit entire institutions while others accredit only particular training programs within an institution. Generally, institutional accreditation is performed by associations of the competing schools themselves, and program accreditation is performed by professional associations.<sup>133</sup> This may suggest that accreditation programs are not just sources of useful information but may also hide conspiracies in restraint of trade.

Inquiry under the antitrust rule of reason should always focus on whether competitor-sponsored accreditation is carried on in ways that minimize its restrictive possibilities. The best way of posing the issue is to

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<sup>133</sup> See COPA, *THE BALANCE WHEEL FOR ACCREDITATION* (1981). Admittedly, it is sometimes difficult to segregate a single program from the institution as a whole; this factor could justify the adoption of the institutional focus in a particular case. Nonetheless, both forms of accreditation are often possible. Both are employed in nursing. See Part One, n. 54 and accompanying text. In one instance a regional institutional accreditor accredited a California law school that the American Bar Association would not approve. See First, *Competition (II)*, *supra* note 130, at 1082-84.



ask whether the program's details and probable effects are consistent with the ostensible procompetitive purpose or instead suggest the existence of an agreement not to compete. Although personnel credentialing schemes in the health care field do not appear to involve agreements to practice only in agreed-upon ways, accreditation programs should be reviewed to make certain that their anticompetitive risks are minimal. The following discussion suggests that, like educational institutions, certifying bodies that join forces to accredit each other must be careful not to overstep the line between setting standards and agreeing not to compete.

#### D. MARKET DIVISION

Although a single certifying body maintaining sensible, nondiscriminatory requirements should have nothing to fear under the antitrust laws, relationships among certifying bodies present some distinct and potentially serious problems. Although complete information on the ABMS is hard to obtain, certain features of the specialty certification system over which it presides suggest that competition across specialty boundaries is adversely affected. A *per se* rule of antitrust law strictly prohibits agreements by which competitors, for no purpose other than to limit competition, divide markets along geographic, product, or customer lines.<sup>134</sup> Even if there is nothing in the ABMS system that qualifies as such a naked restraint of trade, an antitrust court might still find a violation under the rule of reason if it discovers particular practices that offend the policy against unnecessarily confining competitors within specified boundaries.

Because individual physicians do not agree with each other that they will not practice outside their respective specialties, they cannot be charged with the *per se* offense of market division. Even though a few boards do require diplomates to limit their practice to the specialty as defined, these requirements are not enforced and in any event appear to have been imposed by each board independently rather than by agreement with other boards.<sup>135</sup> Moreover, such a requirement, if enforced, would seem to be a

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<sup>134</sup> *United States v. Topco Assocs.*, 405 U.S. 596 (1972); *Timken Roller Bearing Co. v. United States*, 341 U.S. 593 (1951). *See also* *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977) (vertical restrictions on retailers' locations held not subject to *per se* rule applicable to horizontal market division).

<sup>135</sup> Only seven boards mention, in their information to candidates for certification, what could be construed as a practice limitation. Three—the American Boards of Urology, Colon and Rectal Surgery, and Orthopaedic Surgery—require candidates to limit their practice to the specialty. The others—Surgery, Nuclear Medicine, Pathology, and Plastic Surgery—require assurances only to the effect that the candidate be actively or principally engaged in the specialty. *See Kreuzer v. American Academy of Periodontology*, 558 F. Supp. 683 (D.D.C. 1983), upholding a full-time practice requirement as a condition of membership in a dental specialty society. Discussion of this case in Part One, n. 175, suggests that the ADA's ethical

reasonable way to increase the chances that incumbents will maintain their specialized skills. Thus, although the specialty boards have gone rather far toward compartmentalizing medical practice, naked division of the market for physicians' services does not appear to be a significant antitrust problem associated with their operation.

Through the ABMS, the individual medical specialty boards have agreed with each other on the details of training and other indicia of competence in each specialty. The result of these interboard agreements defining the nature and scope of each specialty has been a reduction of competition between specialties, achieved without any agreement by the specialists themselves not to compete. The medical profession's purpose in thus segregating its members into closely defined specialties is not the same, however, as that of the typical market-dividing cartel, which seeks simply to enhance its members' market power and profits by eliminating competition across boundaries. In contrast, compartmentalization of medical practice serves the purpose of standardizing physicians to the greatest extent possible, recognizing the inevitable differences attributable to specialization but maintaining a high degree of actual and apparent homogeneity within each subgroup. Standardization of educational offerings and requirements reduces the temptations and opportunities of individual physicians to obtain special training that would distinguish them from other physicians. In addition, by narrowing the differences that might be advertised, standardization also strengthens the profession's hand in limiting the flow to consumers of unapproved commercial information. Rarely is there much doubt about which type of specialist to consult for a particular diagnosis. By the same token, the need to consult more than one specialist arises with some regularity, suggesting (though not proving) that combinations of skills other than those officially approved might be efficient. Excessive standardization may thus be costly in efficiency terms as well as being inimical to competitive behavior by individual physicians.

Agreements among the ABMS boards that have the effect of limiting interspecialty competition are not necessary to accomplish the boards' procompetitive purpose of producing information helpful to consumers in choosing a specialist. Adequate standardization could be achieved by letting each board define its specialty area as it sees fit, even if some competition between specialties results. Even though the collaborators have purposes somewhat different from those appearing in the typical market-division case, the anticompetitive hazards are clear enough that it would be reasonable to extend the usual *per se* rule against market division to interspecialty agreements arrived at through the ABMS. This legal conclusion results not

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limitations on practice patterns not fitting its defined specialties might be subject to antitrust attack. *Cf. Nara v. American Dental Ass'n*, 526 F. Supp. 452 (W.D. Mich. 1981) (discussed *supra* note 56).

from the blind application of a legal label, but from the rule of reason itself, which contemplates the creation of conclusive presumptions of illegality whenever circumstances, analysis, and experience indicate a high probability that the practice in question will jeopardize competition in the great majority of cases.<sup>136</sup> Although a market-division charge against the specialty-board members of the ABMS would present a legal question of first impression, application of the usual antitrust policy considerations and precedents should satisfy a court that the restraint implicit in interboard agreements defining specialties is a naked one and not ancillary to any legitimate purpose of the boards.

Although competition among physicians is the ultimate antitrust concern, the most telling and helpful way of viewing interboard agreements delineating specialties is to look for effects on competition *among the boards themselves*. The ABMS appears to have compartmentalized not only the physician market but also, and more directly and completely, the production of credentialing information. Each board can appropriately be viewed as a competitor that might, in the absence of ABMS requirements, certify competence in a broader field, providing consumers with an alternative source of information in the areas of overlap between specialties. Thus, interboard agreements limiting the kinds of information that will be produced can readily be viewed as restraints of trade.<sup>137</sup> But, even if one hesitates to characterize interboard agreements as restraints in the market for information, a violation could still be found on the basis of the agreements' adverse effects in the market for physician services.<sup>138</sup> Thus, whether or not the law reaches such agreements directly, this conceptualization should certainly strengthen the argument for finding a *per se* violation under the theory previously advanced.

Whether other accreditors of certification programs present problems comparable to those detected in the operation of the ABMS is not known. The National Commission for Health Certifying Agencies (NCHCA) has published no guidelines endorsing exclusivity in credentialing. Nevertheless, the NCHCA was created as a direct response to a government report deploring the existence in some fields of "two or more certification organizations vying for members within the same occupation and for recognition by public bodies."<sup>139</sup> The authors of that report were attracted by the prospect that the proposed commission would facilitate "mediation of differences among certification organizations,"<sup>140</sup> and endorsed the idea of

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<sup>136</sup> See *National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679 (1978); *Northern Pacific Ry. Co. v. United States*, 356 U.S. 1 (1958). On the extension of the *per se* rule against price fixing in the *Maricopa County* case, see *supra* text accompanying notes 105-07.

<sup>137</sup> See *supra* note 111-14 and accompanying text.

<sup>138</sup> See *supra* note 114.

<sup>139</sup> PUBLIC HEALTH SERVICE, CREDENTIALING HEALTH MANPOWER 7 (1977).

<sup>140</sup> *Id.* at 9.

having "clusters of related occupational categories . . . participate in developing standards for a range of related occupations and levels of competence."<sup>141</sup> Despite this unthinking mandate to violate the Sherman Act, the NCHCA has had sophisticated antitrust advice and may have successfully avoided brokering anticompetitive agreements among bodies seeking its recognition as certifying agencies. In any event, the NCHCA should beware of drawing jurisdictional lines between certifying bodies on the basis of either technical or geographical considerations. Later discussion will suggest the criteria that accreditors of certifying bodies may safely use in carrying out their legitimate functions.

#### E. MERGERS AND JOINT VENTURES IN CREDENTIALING AND ACCREDITING

Recognition of the benefits of competition in credentialing and accrediting suggests that mergers of credentialing and accrediting bodies should be scrutinized under the antitrust laws. Although the form of such mergers might prevent them from being subject to section 7 of the Clayton Act,<sup>142</sup> the Sherman Act's prohibition of "combinations . . . in restraint of trade" should apply because, as argued above, credentialing—that is, the production of commercially valuable information and advice—can readily be viewed as "trade" subject to restraint by an anticompetitive merger. Even if this definition of the market affected by such mergers should be rejected, the possibility of adverse effects on competition in the market for professional services would also expose a merger of two previously or potentially competing credentialing systems to antitrust challenge.

It is difficult to see any procompetitive justification for mergers of credentialing bodies. Unlike industrial mergers, the integration of entities whose only function is to produce information and opinion would seem to offer little, if any, potential for combining complementary resources, realizing production efficiencies, or facilitating capital formation.<sup>143</sup> Although it might be argued that elimination of duplication is itself efficient, that argument assumes that each of the merging credentialing schemes performs the same function, attempting to define the same objective ideal. We have already seen, however, that room frequently exists for valid differences of opinion and philosophy, that bias is unavoidable, and that con-

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<sup>141</sup> *Id.* at 11.

<sup>142</sup> Section 7 of the Clayton Act, 15 U.S.C. § 18 (1981), applies to stock and asset acquisitions by any "person subject to the jurisdiction of the [FTC]." Mergers of credentialing and accrediting bodies involve no stock and could probably be structured to involve no assets. On the FTC's jurisdiction over credentialing and accrediting bodies, see Part One, nn. 184-85 and accompanying text.

<sup>143</sup> On the economic benefits of industrial mergers, see P. AREEDA & D. TURNER, IV *ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION* 146-200 (1980); P. AREEDA, *ANTITRUST ANALYSIS: PROBLEMS, TEXT, CASES* 862-71 (3rd ed. 1981).

sumers can benefit from conflicting advice and from information responsive to their divergent needs and preferences. Even if two competing credentialing systems should seem unnecessary in a particular case, the safer way of eliminating one of them would be simply to force it to close up shop. Allowing it to merge with its competitor would promote no efficiency and save no capital investments or jobs worth mentioning, would eliminate the possibility of ideological rivalry, and would unduly enhance the authority and influence of the resulting credentialing body by widening its sponsorship. In general, such mergers appear to have only the anticompetitive effect of reducing the amount and variety of information and opinion, already undersupplied due to market failure. Because restrictions on the supply of credentialing information can adversely affect the market for professional services, mergers that reduce an already small number of competing sources of useful information and reliable opinion should virtually always be illegal.

Admittedly, it is difficult to analyze mergers of credentialing bodies within the usual framework for appraising the legality of mergers. Indeed, the relevant market is practically impossible to define in terms that permit market shares to be measured and incorporated in a Herfindahl-Hirschman Index of market concentration.<sup>144</sup> If the market is defined narrowly, as the production of formal credentials for personnel in a particular field, most mergers of credentialers would result in a one hundred percent market share and could thus be easily condemned.<sup>145</sup> If, on the other hand, the market were expanded to include substitutes for such credentials—that is, all types of information upon which consumers and others rely in making particular market decisions—quantification would be impossible. Assessment of competitive harm would also be difficult if, instead of focusing on the market for information, one examined the merger's effects in the market for services provided by credentialed personnel. Despite these problems of market definition and measurement of impact, however, some competitive injury should be provable. Consumer

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<sup>144</sup> Mergers are now customarily evaluated under statistical tests set forth in revised guidelines issued by the Justice Department in 1982. U.S. DEP'T OF JUSTICE, MERGER GUIDELINES, 47 Fed. Reg. 38,493 (June 30, 1982). See Symposium, 71 CALIF. L. REV. 281 (1983). See also FTC, STATEMENT CONCERNING HORIZONTAL MERGERS (June 14, 1982), reprinted in TRADE REG. REP. (CCH) No. 546, at 71 (June 16, 1982) (special supplement to 2 TRADE REG. REP. (CCH) ¶ 4225 (Aug. 9, 1982)).

<sup>145</sup> But see *infra* note 152. Another merger arguably involving a smaller market share created the Council on Postsecondary Accreditation (COPA), which accredits educational accreditors. COPA was formed in 1975 by merger of the Federation of Regional Accrediting Commissions of Higher Education and the National Commission on Accrediting. By thus gaining control of nearly 100% of the market for nongovernmental accreditation, COPA hoped to compete with the U.S. Commissioner of Education's growing program to approve accreditors. Shimberg, *The Relationship Among Accreditation, Certification, and Licensure* 15 (1983) (unpublished manuscript).

ignorance looms large in health care markets, and credentialing can be shown to be of vital importance in either the market for information itself or the market for services. Because the usual procompetitive justifications for mergers are generally absent, it should not take much evidence of specific competitive harm to trigger a strong presumption against mergers of credentialing bodies.<sup>146</sup>

The legality of mergers by credentialing bodies has never been challenged, in part perhaps because such mergers have been rare.<sup>147</sup> A recent example of such a merger may be found, however, in the accreditation of continuing medical education (CME) programs. In 1979, as a result of philosophical differences, the AMA withdrew from the Liaison Committee for Continuing Medical Education (LCCME) and set up its own competing accrediting body.<sup>148</sup> After operating separately for less than two years, during which time the desire was expressed "that the differences between the AMA and the LCCME be resolved through discussion and negotiation,"<sup>149</sup> the two accreditors rejoined to become the Accreditation Council on Continuing Medical Education (ACCME).<sup>150</sup> Under the analysis suggested here, this merger is suspect.

Competition in the accreditation of CME programs seems distinctly preferable to the monopolistic situation created by the AMA-LCCME merger. There is room for wide differences of opinion about which CME

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<sup>146</sup> One can imagine cases in which the merging credentialing bodies have other functions that may be efficiently integrated. For example, two professional associations providing lobbying and other services to their members might seek to merge. Even in such cases, however, the rule should be, as usual, that the elimination of desirable competition in any market invalidates the merger. *See, e.g.,* *Brown Shoe Co. v. United States*, 370 U.S. 294, 311-23 (1962); *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 370 (1963). Possibilities for spinning off one of the competing credentialing programs should therefore be considered.

<sup>147</sup> Though their actions do not constitute a merger of credentialing bodies in the sense discussed here, several states have virtually eliminated the distinction between osteopathy and allopathic medicine. *See* *New York State Osteopathic Soc'y v. Allen*, 26 N.Y.2d 20, 256 N.E.2d 510, 308 N.Y.S.2d 342 (1970), where the plaintiff society sought unsuccessfully to compel New York State to remove M.D. degree designations from the licenses of fifty D.O.s who were graduates of a California college of osteopathy that later became a medical school; *Osteopathic Physicians and Surgeons of Cal. v. California Med. Ass'n*, 224 Cal. App. 2d 378, 36 Cal. Rptr. 641 (1964) (merger agreement between defendant and California Osteopathic Association held valid). *See also* Editorials, 70 J. AM. OSTEO. ASS'N 13 (1970); 69 J. AM. OSTEO. ASS'N 317, 445 (1969). The loss of the distinction between different philosophies has potentially adverse consequences for competition. *See* references cited *supra* note 80; Part One, nn. 109, 205.

<sup>148</sup> As its reason for withdrawal, the AMA cited "fundamental differences in philosophy between AMA and LCCME in the approach to establishing and maintaining standards, and the evaluation of continuing medical education." AMA, *79th Annual Report on Medical Education in the United States*, 243 J. A.M.A. 842-43 (1980).

<sup>149</sup> AMA, *80th Annual Report on Medical Education in the United States*, 244 J. A.M.A. 2805, 2806 (1980).

<sup>150</sup> AMA, *81st Annual Report on Medical Education in the United States*, 246 J. A.M.A. 2911 (1981). Representatives of the Federation of State Medical Boards and the Association for Hospital Medical Education were added to the membership at that time.

programs actually improve practitioners' skills.<sup>151</sup> Alternative accreditation schemes might be helpful in highlighting differences among programs that would be of interest to physicians and to such third parties as hospitals, employers, credentialing bodies engaged in recertification, public licensing bodies administering a CME requirement, and tax collectors concerned about the deductibility of expenses for attending CME programs in exotic climes.<sup>152</sup> Although the dispute between the LCCME and the AMA was primarily a power struggle focusing on the prerogatives of state medical societies,<sup>153</sup> substantive differences also appeared before and after the split.<sup>154</sup> Pressure for a prompt merger reflected "concern that the separate policies and procedures of the two organizations might drift farther apart if there were any considerable delay,"<sup>155</sup> and competing sponsors of CME

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<sup>151</sup> The vast body of CME literature demonstrates a wide range of possible types, formats, and levels of CME, as well as great disagreement over both goals and means. CME can be geared to requirements for state relicensure, medical specialty society membership, or board certification—each meeting different standards for breadth and depth of knowledge. It can be offered by a specialty board or society, a state licensure board, a hospital, a medical school, or a private commercial organization—each with a different focus or emphasis. It can also take many forms: standardized testing, self-assessment, formal course work, weekend lectures, clinical requirements, or personal reading. And it may be either narrowly or broadly related to the physician's practice. See generally H. SHUCHMAN, SELF-REGULATION IN THE PROFESSIONS 237-42 (1981); B. SHIMBERG, OCCUPATIONAL LICENSING: A PUBLIC PERSPECTIVE 122-37 (1980); Bloom, *Second Thoughts on CME*, MED. WORLD NEWS, Nov. 12, 1979, at 53; Stein, *Accreditation of Continuing Medical Education and Public Credibility*, 55 BULL. N.Y. ACAD. MED. 346 (1979); AMA, *78th Annual Report on Medical Education in the United States*, 240 J. A.M.A. 2848 (1978); Lewis & Hassencin, *Continuing Medical Education—An Epidemiological Evaluation*, 282 NEW ENG. J. MED. 254 (1970).

<sup>152</sup> In fact, a few specialty societies have their own accreditation schemes and require that CME programs offered to their members meet those requirements as well as the ACCME's. Most notably, the American Academy of Family Physicians, the first specialty society to require CME, has maintained a separate system since the 1940's, and in 1976 the American College of Emergency Physicians instituted an accreditation requirement to "complement" existing accreditation. See Bloom, *supra* note 151, at 54; Stein, *supra* note 151, at 347. The availability of alternative CME accreditors would be relevant to the legal analysis of a merger. See *supra* note 145 and accompanying text.

<sup>153</sup> See Petty, *Political Gains, Grassroots Problems*, MED. WORLD NEWS, June 9, 1980, at 39, 50; *AMA Dumps Cohorts in CME Accrediting*, MED. WORLD NEWS, Aug. 20, 1979, at 11; *AMA to Resume Responsibility for Accrediting CME Programs*, AM. MED. NEWS, Aug. 3-10, 1979, at 1.

<sup>154</sup> The philosophical differences asserted to exist between the AMA and the other component organizations of the LCCME included disagreement over the place of federal funding in medical education, the needs and proper contributions of practicing physicians in CME and CME accreditation, and the role of state medical societies in accreditation. See, e.g., AMA, *supra* note 148; *CME Schism*, MED. WORLD NEWS, Nov. 12, 1979, at 60. Other differences appeared to exist as well. The AMA's accreditation was geared primarily to small traditional teaching settings, and its CME requirements were broad minimal standards. See Stein, *supra* note 151. During the "schism," the LCCME proposed changes that would have made standards more exacting and provided for greater curriculum flexibility. See *A Proposal for Sweeping Changes in CME*, MED. WORLD NEWS, Feb. 18, 1980, at 22. After remerger, the new ACCME adopted changes which resemble, but fall short of duplicating, those proposals. See *CME Criteria Made More Exacting*, MED. WORLD NEWS, Feb. 15, 1982, at 29.

<sup>155</sup> AMA, *supra* note 149, at 2806.

programs complained about having to decide whether to meet varying requirements.<sup>156</sup> Because the ACCME appears to have suppressed emerging diversity and experimentation in the CME field, a challenge to its formation by merger would seem justified not only by the letter of the law but by policy considerations as well.

More common than mergers, but subject to similar analysis, are joint ventures by bodies that could act as independent credentialers or accreditors but have not done so. One way of judging the legality of such joint ventures is to focus on the loss of potential competition. Mergers and joint ventures have sometimes been held to harm competition in a highly concentrated market even though neither party had actually competed in that market. If both parties would have entered the market independently had they not joined forces, the harm to competition is reasonably clear, but the Supreme Court has also held that a joint venture may be unlawful even though only one of the two partners would have actually entered the market, if the other would have remained "at the edge of the market, continually threatening to enter."<sup>157</sup> In theory, this competitive entry threat, can induce better performance by the market's few firms, which might otherwise behave as an oligopoly.

Such a potential competition theory could be used to challenge most credentialing or accrediting joint ventures, because the parties to such ventures are usually the organizations most likely to undertake credentialing or accrediting on their own. Again, the field of CME accreditation provides a helpful example. The LCCME, from which the AMA broke away in 1979, was originally formed in 1975 as a joint venture of the AMA and several other organizations.<sup>158</sup> Because the AMA was at the time the sole CME accreditor and because the AMA's partners were virtually the only entities in a position and with an incentive to enter the field, the joint venture eliminated important potential competition.<sup>159</sup> Although potential

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<sup>156</sup> See *id.*; *CME Schism*, *supra* note 154. It is notable that the brief existence of competing accreditation schemes for CME created no reported problems for consumers of CME but "engendered a substantial amount of confusion and disarray among organizations and institutions offering continuing education programs." *Id.* (emphasis added). Though complaining of confusion and increased paperwork, CME program sponsors probably were troubled also by the prospect of diversity in the marketplace and the need to choose a competitive response.

<sup>157</sup> *United States v. Penn-Olin Co.*, 378 U.S. 158, 173 (1964). See also *United States v. Falstaff Brewing Co.*, 410 U.S. 526 (1973); Brodley, *Potential Competition Mergers: A Structural Approach*, 87 YALE L.J. 1 (1977).

<sup>158</sup> The LCCME was formed in 1975 by representatives from the ABMS, the Council of Medical Specialty Societies, the Association of American Medical Colleges, the American Hospital Association, and the AMA, whose Council on Medical Education had since 1966 acted as sole accreditor of CME programs. See AMA, *supra* note 151, at 2813.

<sup>159</sup> A similar analysis might be applied to the AMA's Accreditation Council for Graduate Medical Education (ACGME), whose task it is to accredit residency programs. The ACGME is comprised of representatives of the Association of American Medical Colleges, the ABMS, the American Hospital Association, the AMA, and the Council of Medical Specialty Societies. See



competition theories are frequently troublesome and hard to employ with confidence in specific cases, their use in evaluating joint ventures for credentialing and accrediting presents few problems because of the high level of concentration typically found in these activities and the small number of entities capable of engaging in them.<sup>160</sup>

A slightly different way of analyzing joint credentialing and accrediting efforts would be to focus on a larger relevant market, one that includes information and opinion published in forms other than certification or accreditation. The various influential professional organizations that joined the AMA in forming the LCCME, though not engaged in accrediting CME programs as such, may nevertheless have been effectively competing with the AMA in the production of information and opinion concerning CME by publishing their views in a less formal fashion, by publicly criticizing the AMA's policies, and in other ways. According to this wider view of the relevant market, inclusion of any prominent source of information and opinion in a joint venture with the sole credentialer or accreditor could be seen as eliminating actual, not merely potential, competition. Although this definition of the market presents problems of measurement and evaluation, it calls needed attention to the already small number of alternative sources of authoritative information and opinion on specific health care topics and suggests how joint ventures reducing that number can have destructive market effects that should invite antitrust scrutiny.

A broad market definition such as that just suggested presents some additional difficulties because it threatens to extend antitrust law outside the commercial realm and into the larger marketplace of ideas. Indeed, it would seem to expose any substantial entities capable of disagreement about any subject to antitrust scrutiny if they should attempt to merge or even to compromise their differences. There is ample precedent, however, for not construing the antitrust laws to extend into the political arena,<sup>161</sup> and it should not be difficult to focus the law exclusively on protecting competition in the production of information and opinion directly targeted at informing commercial decisions.<sup>162</sup> Partly because of the quasi-

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AMA, *supra* note 150. Like the ACCME, the ACGME constitutes an illegal joint venture under the theory advanced here.

<sup>160</sup> See generally Brodley, *Potential Competition Under the Merger Guidelines*, 71 CALIF. L. REV. 376 (1983); Brodley, *supra* note 157; Turner, *Conglomerate Mergers and Section 7 of the Clayton Act*, 78 HARV. L. REV. 1313, 1384-86 (1965).

<sup>161</sup> *United Mine Workers v. Pennington*, 381 U.S. 657 (1965); *Eastern R.R. Presidents Conference v. Noerr Motor Freight*, 365 U.S. 127 (1961); *Missouri v. NOW*, 620 F.2d 1301 (8th Cir.), *cert. denied*, 449 U.S. 842 (1980).

<sup>162</sup> If the joint venturers are each competitor-sponsored, their credentialing or accrediting might be said to involve commercial speech, which is entitled to somewhat less first amendment protection than other kinds of speech. See Part One, nn. 215-22 and accompanying text.

constitutional difficulties inherent in a broad market definition, courts might be most comfortable in identifying credentialing or accrediting alone as the relevant market, relying on the potential competition theory to reach joint ventures that eliminate discordant voices and helpful criticism.

Perhaps the best way to see the competitive harm resulting from credentialing and accrediting joint ventures is to recognize that the prestige and influence of a particular program is likely to be much greater if it is sponsored by a group that purports to incorporate all affected interests. By the same token, a program sponsored by an organization that has narrow and recognizable interests and that is subject to public criticism by other, similar organizations is likely to have its authority and standards questioned and to find that its influence depends on its powers of persuasion rather than its status. In short, if monopolization of the market for information and opinion can be avoided, people will be able to turn to alternative sources for help and advice, and consumers will be better served. The payoff from a more diverse and competitive market for information will of course not take the form of lower prices for information itself, which is not bought and sold, but will be realized instead in the related market for services. Whichever market is chosen as the relevant one for antitrust analysis, however, the result should be the same.

The legal theories suggested here for evaluating joint credentialing and accreditation activities have portentous implications for several well entrenched self-regulatory mechanisms in the health care industry. In the credentialing of nonphysician health manpower, for example, it has been customary for the AMA to join forces with the dominant professional association in each occupational field to express a single opinion about educational standards and the specific training and qualifications that personnel should possess.<sup>163</sup> Such collaboration in credentialing ensures that only one authoritative voice will be heard on such crucial issues as the nonphysician practitioners' scope of practice, their breadth of training, the nature and extent of subspecialization, their place within organizational frameworks, and their relationships with physicians. Whereas the medical profession and the various occupational groups whose training and qualifications are overseen can be expected to have sharply different views and interests on many points, this natural tension and competitiveness are sublimated and internalized within the joint venture, to be dealt with by political bargaining rather than allowed to erupt in unwanted economic competition or public disputation. The resulting standardization is likely to be excessive, and the quantity of information and opinion available to the public will be less than it would otherwise be.

One nonphysician manpower field where competition in credentialing and accrediting currently exists is physical therapy, where a major schism

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<sup>163</sup> See Part One, nn. 52-57 and accompanying text.

occurred in the 1970s. The coexistence of accreditation programs sponsored by the AMA and the American Physical Therapy Association (APTA) demonstrates the feasibility of competition and suggests some of its possible benefits. Although physical therapy training programs have generally sought both accreditations, the standards of the two accreditors differ markedly: APTA's emphasize training in treatment planning and generally contemplate therapists capable of greater independence than AMA interests would approve. Although most state laws still limit the scope of therapists' practice and require their subservience to physicians, therapists have made substantial de facto gains in these areas in recent years, in large part because of their break with the AMA.<sup>164</sup> If joint ventures for credentialing and accrediting were subject to scrutiny as restraints on the competitive production of commercially valuable information and opinion, other nonphysician professionals would likewise be freer to compete for larger roles. Competition in credentialing and accrediting should be enforced by law and should not have to await some breakdown in the AMA's relations with a previously "allied" profession.

Another candidate for challenge under the legal theory advanced here is the LCME, the AMA's joint venture with the Association of American Medical Colleges (AAMC) for accrediting medical schools. These two partners have somewhat different ideas about medical education but have agreed to settle their differences within the LCME framework instead of publishing conflicting views.<sup>165</sup> A contrasting situation prevails in the legal

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<sup>164</sup> See generally 3 LEWIN REPORT, *supra* note 31, at 38-41. The AMA and the APTA collaborated in accrediting physical therapy training programs from the 1930s until their split in 1976, which resulted from a long disagreement. The AMA's current Essentials define the physical therapist's role as strictly secondary to the referring physician's. See JOINT REVIEW COMM. FOR PHYSICAL THERAPY EDUCATION, ESSENTIALS AND GUIDELINES FOR ACCREDITED EDUCATIONAL PROGRAMS FOR THE PHYSICAL THERAPIST (1979). On the other hand, the APTA expects programs to train therapists to design, manage, and implement care plans independently of the referring practitioner. See APTA, STANDARDS FOR ACCREDITATION OF PHYSICAL THERAPY EDUCATIONAL PROGRAMS (1978). In practice, most training programs have dual accreditation and prepare students for the widest scope of practice permitted by state laws, which vary in restrictiveness and are subject to liberalization. Even in restrictive states, many referring physicians allow therapists to exercise independent judgment. Although significant practice issues still exist with respect to supervision, referral, and reimbursement, there appears to be a trend towards greater flexibility, largely as a result of the APTA's efforts and influence.

<sup>165</sup> For a recent example of disagreement, see Lewis, *supra* note 20. The position reported in this news report conflicts with stated AMA policy, as discussed in *id.* and in AMA, *supra* note 20.

Another useful example of the differing opinions of competitors over operating standards involves free-standing emergency care centers. The AMA has promulgated guidelines proposing staffing, supplies, and hours of operation that differ from the standards applied by the National Association of Freestanding Emergency Centers (NAFEC). See *Trade Restraint Suit Filed Against AMA*, MED. WORLD NEWS, Aug. 8, 1983, at 75; *Urgi-Centers Say AMA Restrains Trade*, 12 HEALTH POL'Y WEEK, July 18, 1983, at 3. NAFEC has complained to the FTC that the AMA seeks to squelch competition by enforcing its guidelines. Absent proof of a boycott, however, the AMA should be free to opine as to what constitutes a safe emergency center, just

profession, where the American Bar Association and the Association of American Law Schools maintain separate accreditation systems. Although law school visitations are usually made jointly for efficiency reasons, different standards are employed, and different conclusions are reached with respect to a substantial number of schools. It is impossible to say whether this competition has paid great or only modest dividends for the public, but it has made somewhat more information available concerning marginal schools and may have highlighted some issues that would have been quietly resolved within an accrediting joint venture.<sup>166</sup> In any event, it is apparent that concurrent accrediting systems can coexist in professional fields.

Medical school accreditation played a major role in knitting the medical profession into a cohesive entity and in building the ideology of medical care that still pervades the profession. The authoritative status of the LCME (and its forerunners) enabled the profession to lobby successfully for its incorporation by reference in state licensure laws, which currently allow only foreign graduates to sit for licensure exams without graduating from an LCME-accredited school. If medical schools were accredited on a competitive basis or by an organization having a base narrower than the LCME's, states might revise these laws, making it easier for competitive schools to enter the market in some states<sup>167</sup> and eliminating the necessity for competitors to set themselves up in foreign countries. A change in the auspices of accreditation might also be helpful in promoting educational diversity. Although there is no way of knowing whether the current accreditation system unduly inhibits innovation, the historical record indicates that the problem was once severe,<sup>168</sup> and certainly there is no lack of complaint about the existing educational system.<sup>169</sup> Anything that suppress-

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as NAFEC is free to differ. Joint promulgation by these bodies of negotiated standards acceptable to both would appear to deny consumers clearly valuable information.

<sup>166</sup> Two articles by Professor First suggest that the ABA and AALS have operated in concert, applying almost identical standards. First I and First II *supra* note 130. *But see* Vernon, *President's Message*, AALS NEWSLETTER, Feb. 1983, at 1 (predicting increasingly different roles for the two accreditors, with the AALS setting high standards emphasizing a scholarly orientation).

<sup>167</sup> In contrast to the universal requirement that only graduates of accredited (or foreign) medical schools may seek state licensure, only twenty-six states specifically limit bar examination admission to graduates of ABA-accredited law schools, and no state requires AALS accreditation. An additional twenty states impose some form of accreditation requirement, usually requiring accreditation but not specifying the ABA as the only acceptable accreditor. In a few instances, graduates of unaccredited schools must demonstrate receipt of an equivalent education. Although these laws considerably reduce the opportunities of non-ABA law schools, such schools do exist and prosper in a few places. *See* First I and First II, *supra* note 130; Fossum, *Law School Accreditation Standards and the Structure of Legal Education*, 1978 AM. BAR FOUND. RESEARCH J. 1515.

<sup>168</sup> *See supra* notes 9-11.

<sup>169</sup> *See, e.g.*, sources cited *supra* notes 11 and 13.

es responsible diversity in education and propagates a particular ideology raises serious concerns in a nation that prides itself on its tradition of free inquiry.<sup>170</sup>

Perhaps the most prominent candidate for challenge as an anticompetitive joint venture under the legal theory advanced here is the Joint Commission on Accreditation of Hospitals (JCAH), a joint undertaking of the AMA, the American Hospital Association (AHA), the American College of Surgeons (ACS), and the American College of Physicians (ACP). Each of these organizations represents a constituency having a unique perspective on the issues that arise in organizing and operating a high quality hospital. Although intraprofessional debates occur over JCAH standards, the four JCAH sponsors have agreed among themselves not to express their separate views for the benefit of consumers and instead to arrive at and abide by a common position expressed through the JCAH. Each is capable, however, of undertaking hospital accreditation on its own—indeed, the ACS developed the original program by itself<sup>171</sup>—or of offering its views on hospital organization and operation in some other helpful form. Moreover, there are few, if any, equally capable entities and only a handful of other authoritative sources of information and opinion. A joint venture eliminating competition among the four dominant firms in any industry is normally subject to the closest antitrust scrutiny, and probably not even compelling proof of scale economies could overcome the presumption against such collaborations. There is no apparent reason why this principle should not apply to a joint venture to accredit hospitals.

Though breaking up the JCAH would be a radical step, it would not create chaos. The JCAH hospital accreditation effort is financially self-supporting, and its staff and other resources could be kept intact and simply operated under different auspices, either as an independent body or by one of its current sponsors. Whether any competing accrediting

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<sup>170</sup> An obvious corollary to this argument is that the Secretary of Education should withdraw recognition of the LCME as an accreditor of medical schools. Even if the Secretary is unwilling to decide that its joint sponsorship violates the Sherman Act, he would still be free to act on the basis of a natural and appropriate concern for educational diversity. See Boyer letter, *supra* note 10, at 15. A decision to cease recognizing the LCME might stimulate its reorganization under different auspices or the creation of new accreditors better situated to express and implement divergent philosophies of medical education and care.

<sup>171</sup> See R. STEVENS, *supra* note 11, at 87, 91-92, 119; Affeldt, *Voluntary Accreditation*, in *REGULATING HEALTH CARE: THE STRUGGLE FOR CONTROL* 182 (A. Levin ed. 1980). The ACS apparently developed its first hospital standards largely to ensure that hospitals kept records sufficient to permit evaluation of candidates for ACS fellowship on the basis of their past surgical performance. If the formation of the JCAH in 1952 was lawful because, say, the ACS could no longer afford to support the scale of effort needed, it would not follow that the joint venture, which operates under a continuing agreement, remains lawful today. The venture's legality is a function of circumstances and may change over time. Cf. *United States v. Pan Am. World Airways*, 193 F. Supp. 18 (S.D.N.Y. 1961), *rev'd on other grounds*, 371 U.S. 296 (1963).

system would be established would depend upon many things. Even if there continued to be only one accrediting system, however, its prestige would be less than that of the JCAH, partly because of the criticism to which it would be publicly subjected by its former sponsors.<sup>172</sup> In any event, the possibility certainly exists that if, for instance, the AMA took over the accreditation function, hospital interests would soon establish their own, less physician-oriented standards. Perhaps the chief benefit of changing the auspices under which hospital accreditation is carried on would be the reduction of physician influence, through JCAH standards, over the internal organization of hospitals.<sup>173</sup> Thus, although a physician organization might continue to insist, as a condition of accreditation, that hospitals should not open their staffs to nonphysicians,<sup>174</sup> the influence of that standard and others like it could be expected to diminish over time. There is of course no way to establish a perfect market in which decisions about hospital quality or similar issues could be entrusted entirely to consumer choice, but it does appear possible and desirable to reduce the power of cooperating industry groups to keep vital decisions in their own hands.

The legal theory advanced here for challenging mergers and joint ventures in the market for information does not appear to have been

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<sup>172</sup> If break-up of the JCAH should significantly diminish the prestige associated with accreditation, the successor accreditor might not be able to charge accreditation fees sufficient to support a review effort as extensive as the present one, and any resulting loss in the quality of accreditation services might be urged as a basis for permitting the more broadly-based joint venture. One answer to this argument might be that a joint venture's enhancement of competition in one market (e.g., information) cannot be used to justify adverse effects on competition in another market (e.g., services). *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 370 (1963); *United States v. Topco Assocs., Inc.*, 405 U.S. 596, 611-12 (1972) (principle stated but misapplied when all effects were within a single market for retail groceries). In addition, however, even if one concentrates on the separate market for information, it is quite possible the consumers would be better served by sacrificing some economies of scale that permit thoroughness in hospital accrediting and by fostering diversity in ideas about hospital quality. In any event, changing the sponsorship of the JCAH's accreditation program would not interfere with its ability to realize scale economies or even to operate as a natural monopoly. *See supra* notes 70-75 and accompanying text. Any adverse consequences resulting from its loss of prestige or credibility would be attributable not to a loss of efficiency but to an appropriate strengthening of competition in the information marketplace.

<sup>173</sup> The organizational structure of hospitals has been convincingly shown to be inefficient from the standpoint of cost containment because of a lack of control over physicians. Harris, *Regulation and Internal Control in Hospitals*, 55 BULL. N.Y. ACAD. MED. 88 (1979); Harris, *The Internal Organization of Hospitals and Economic Implications*, 8 BELL J. ECON. 467 (1977). Although Harris does not so observe, this inefficient structure did not become nearly universal by chance or by the operation of market forces but is attributable in large measure to physicians' collective influence and to JCAH standards dictated by the needs and priorities of physicians.

<sup>174</sup> For discussion of an antitrust attack on JCAH standards to this effect, see Part One, text accompanying nn. 176-78, where it is argued that such a standard should be upheld. Nevertheless, fearing antitrust liability for adhering to a standard having exclusionary effects, the JCAH has recently revised its position on clinical privileges for nonphysicians. *See JCAH Votes for Hospital Option in Granting Admitting Privileges to Non-MD's*, MED. WORLD NEWS, Jan. 9, 1984, at 9.

previously proposed. Though it appears radical and would certainly upset some established institutions, it follows inexorably from a recognition that information and opinion helpful in making market decisions are valuable commodities whose output, always at suboptimal levels in any event, is subject to restraint by self-interested industry groups. This Article seeks to demonstrate the desirability of ensuring that such information and opinion are produced under competitive conditions and the logic of and legal basis for challenging mergers and joint ventures in credentialing and accrediting under the antitrust laws.

## VII. TWO TESTS OF THE THEORY

Part One of this Article argues against legal intervention to remedy any but obvious instances of unfair and deceptive credentialing. The force of that argument is increased substantially by the foregoing demonstration that the market for consumer information can be made significantly more competitive and dynamic than it has been heretofore. Because the market can provide new checks on deceptive credentialing, it should be easier to conclude that judicial intervention is not needed to correct all arguable abuse. Perhaps consideration of two specific issues will help the reader to appreciate the logic and relation of the arguments advanced.

### A. HIGHER-TIER ACCREDITING (CERTIFYING THE CERTIFIERS)

A special question may be raised concerning the scope of judicial review of the standards employed by the ABMS, the NCHCA, and similar organizations (of which there are very few)<sup>175</sup> in accrediting entities that are themselves engaged in certifying or accrediting at a lower level of the market. Part One observes how such higher-tier accreditors can help consumers and others decide whether to trust the judgment of a particular credentialing or accrediting program. Indeed, accreditation at this level helps to solve for consumers and others essentially the same kind of quality-information problems that certification and accrediting help to solve in markets for consumer goods and services. The question considered here is whether an organization engaged in such higher-tier accreditation should be subject to any special common-law or antitrust restrictions on its freedom to refuse accreditation to entities that threaten to strengthen

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<sup>175</sup> Other private higher-tier accreditors are the Council on Postsecondary Accreditation (COPA), a private accreditor of educational accreditors, *see supra* notes 133, 145, and the American National Standards Institute (ANSI), a coordinator of industrial standards bodies and certifiers. *See* SCIENCE POLICY RESEARCH DIVISION, CONGRESSIONAL RESEARCH SERVICE OF THE LIBRARY OF CONGRESS, REPORT TO THE SUBCOMMITTEE ON SCIENCE, RESEARCH AND DEVELOPMENT OF THE HOUSE COMMITTEE ON SCIENCE AND ASTRONAUTICS, VOLUNTARY INDUSTRIAL STANDARDS IN THE UNITED STATES 28-31 (1974); FTC, PROPOSED RULE AND STAFF REPORT, STANDARDS AND CERTIFICATION 18-20 (1978).

competition with the organization's sponsors. This issue is similar to that which Part One examines—namely, the extent to which a court should seek to ensure that a competitor-controlled entity acts fairly toward outsiders seeking its recognition. In reviewing the comparable problem as it arises among competing health care practitioners, Part One argues that only limited judicial oversight is appropriate in reviewing the standards and procedures employed by certifying and accrediting bodies. There is no reason to depart from this conclusion in looking at higher-tier accreditors.

At first glance, there is an attractiveness to a rule that would force higher-tier accreditors to be concerned only with the applicant's performance of the mechanical task of credentialing or accrediting—that is, its impartial application of standards—and to ignore the substance of the standards themselves. One possible formulation of such a rule would be to confine higher-tier accreditors, as Part One argues courts should be confined, to exercising only limited scrutiny of credentialing and accrediting programs. The argument for some such curtailment of accreditors' power to pass substantive judgments would be similar to that underlying the policy of the Department of Education in focusing exclusively on structural and procedural matters in recognizing educational accreditors.<sup>176</sup> If the higher-tier accreditor were required to grant or withhold approval only on the basis of a program's integrity and fairness and prohibited from considering the substance of its standards, the ideal of pluralism would be well served. At that level—the peak of the pyramid as it were—the likelihood of monopoly is high and the case for suppressing the influence of ideology and self-interest in accreditation standards is strongest.

Despite its seeming symmetry, however, any such attempt to limit the scope of higher-tier accreditation must be rejected as highly artificial. Higher-tier accreditors are unlikely to be interested only in mechanics. Competing certifiers ordinarily do not undertake higher-tier accreditation as a way of competing more effectively in the technical business of certifying. Instead, they are more likely to be interested in affecting outcomes in the market for services by increasing the credibility and influence of certain certifiers at the expense of others. Indeed, the parties most interested in accrediting at this level will often be those competing in the ultimate service market—*e.g.*, physicians. Even though the issues in higher-tier accrediting may seem to involve only technical questions of how competence or quality can best be determined, the answers to such questions very often turn on philosophical preferences, professional considerations, and economic biases originating in the market for services.<sup>177</sup> A dynamic marketplace of

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<sup>176</sup> See discussion in Part One, nn. 14, 199 and accompanying text.

<sup>177</sup> The NCHCA appears to be sincerely devoted to the purely technical improvement of the certification function. See *supra* text accompanying notes 139-41. As prior discussion has made clear, however, even the most straightforwardly "technical" standards and quality



ideas would seem to require preserving higher-tier accreditation as an available avenue for asserting views on professional questions and for attempting to establish the trustworthiness of particular credentials.

The monopoly argument in favor of closely policing the accreditation of credentialers and accreditors likewise fails—for reasons that should now be familiar. Even if it is carried out by a *de facto* monopoly, accreditation is nothing more than an expression of opinion, and it is influential only to the extent that independent decisionmakers accept the accreditors' judgments. In addition, it remains subject not only to actual competition in the form of other information and less formally expressed opinion and criticism but also to potential competition in the form of a new accreditor. Even if organized medicine dominated an area of higher-tier accrediting, as it appears to do currently through the ABMS, its policy positions on the many questions at issue in lower-level certification or accreditation would be of great interest to consumers and others, and there are good reasons to be found in both the first amendment and free-market principles for not limiting the profession's right to express its approval or disapproval of particular certification or accreditation programs. In this situation, higher-tier accreditation appears to serve the same useful purposes as a commercial trademark in signifying the auspices under which particular certifying or accrediting is carried on; it is not too much to expect that most users of the information will understand when an accreditor is engaged in drawing vertical rather than exclusively horizontal lines.

Under the approach suggested here, a higher-tier accreditor comprised of competitors in the production either of information concerning services or of the services themselves would remain subject to some scrutiny if it should refuse to recognize a particular credentialing or accrediting body. But, if its reasons for such refusal—that is, its accrediting standards—bore a rational relationship to any procompetitive purpose, no common-law or antitrust violation should be found. Here, as before, the key to procompetitiveness lies in the needs and interests of consumers and other commercial users of the information being conveyed. Thus, any distinctions drawn by the accreditors must be such as would be regarded by a significant number of independent users of the information as relevant to their market choices—not necessarily as the best possible or most desired information, but at least as useful and relevant to their specific concerns. On the other hand, courts should feel free to invalidate standards that penalize aggressive competition or that betoken agreements among the accredited certifiers or accreditors themselves (or among their sponsors) not to compete in lawful ways. In general, it would appear that the princi-

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judgments inevitably incorporate ideology and opinion at the certification level. *See* Part One, nn. 200-07 and accompanying text; *see also supra* notes 76-78 and accompanying text. There is no reason to expect that the decisions of higher-tier bodies are less entangled with non-objective factors.

ples developed in Part One can be applied to higher-tier accrediting without appreciable difficulties. The only special point is that anticompetitive effects of such accrediting should be looked for in both the market for information and the market for services.

#### B. A PROBLEM OF REMEDY

There is a significant danger that a court which generally accepts the analysis in this Article would nevertheless ignore Part One's recommendations in favor of only limited scrutiny in a case where the sponsorship or constitution of the defendant credentialing body raised doubts under the theories advanced in Part Two. Such a court might reason that, if the defendant appears to be an unlawful joint venture, there can be no harm in closely policing its conduct if that is the relief the plaintiff requests. This thinking would be mistaken. An unlawfully constituted credentialing body's unfairness toward particular competitors should not be regarded as a lesser included offense (of the structural violation) at which a conduct-oriented remedy can be aimed for the benefit of the injured competitor-plaintiff. Instead of leaving the larger question of structural violation to be dealt with in another case—perhaps one brought by a public prosecutor—the court should insist that the plaintiff prove that violation and request a remedy aimed at its extirpation. If there is no violation under the limited scrutiny test, then no conduct-oriented relief should be granted.

The courts are likely to confront this remedy question frequently because private plaintiffs will usually prefer to seek a more limited remedy rather than to attack the sponsorship of the defendant. Although this preference may simply reflect a fear that seeking structural relief will involve a greater litigation burden,<sup>178</sup> plaintiffs may have a more troublesome reason for seeking narrower relief: Forcing their way into the exclusive club may be more advantageous to them than destroying the club and restoring competition.<sup>179</sup> By the same token, the public loses something if the narrower relief is granted. Thus, plaintiffs should be denied both damages and specific relief addressed to their particular competitive

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<sup>178</sup> Under the theories advanced above, however, proof of a structural violation might be somewhat easier than proof of a particular standard's invalidity.

<sup>179</sup> By means of a conduct-oriented remedy, plaintiffs can obtain credentials that give them market power and a status apparently equivalent to that enjoyed by individuals already possessing those credentials; a structural remedy, on the other hand, would not entirely eliminate the differentiation and competitive disadvantage of which the plaintiff complains. Similar problems arise under the "essential facilities" doctrine of antitrust law discussed in Part One, text accompanying nn. 151-53. *See, e.g.,* *United States v. Terminal R.R. Ass'n*, 224 U.S. 383 (1912), which Judge Posner has suggested merely vindicated the interests of a railroad "complaining about its exclusion from a cartel." *Marrese v. American Academy of Orthopaedic Surgeons*, 706 F.2d 1488, 1495 (7th Cir. 1983).

difficulties unless they select the line of antitrust attack that is most likely to benefit the community at large.<sup>180</sup> In cases where the finding of a violation results not from limited scrutiny but from a structural defect, courts should decline to provide a remedy that leaves the monolith intact with the plaintiffs inside it.

One prominent recent case may have presented this problem of remedy in a slightly different but not too dissimilar context and may have resolved it in a fashion contrary to the recommendation made above. In *Virginia Academy of Clinical Psychologists v. Blue Shield*,<sup>181</sup> plaintiff psychologists (VACP) successfully challenged refusals by two Blue Shield plans to pay for the services of clinical psychologists unless they were billed through a physician. The court of appeals found "sufficient physician control of Blue Shield of Richmond to bring its actions within the purview of section 1 of the Sherman Act"<sup>182</sup> and seemed prepared to grant the plaintiffs specific relief from the discriminatory practice. Although physician control of the Blue Shield plan might have been attacked directly under theories amply developed by the FTC,<sup>183</sup> plaintiffs had good reason to prefer narrow injunctive relief over a decree severing the control relationship between the medical profession and the insurer: The latter relief would have left them with no assurance that the newly independent Blue Shield plan would do business with them on the desired terms. Indeed, the business reasons advanced by the plan in defense of the discriminatory practice were quite convincing, suggesting that the practice should not have been struck down if the plan were a legitimate joint venture and therefore that the true vice was indeed professional control.

The *Virginia Academy* case can thus be read as allowing a limited, conduct-oriented remedy based on the existence of a recognized, but unremedied, structural violation, and thus as precedent for forcing an improperly constituted certifying body to award a plaintiff credentials that it had unfairly denied him.<sup>184</sup> The case may also be read, however, as a

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<sup>180</sup> One problem with this suggestion is that a defendant is unlikely to defend on the ground that the plaintiff failed to challenge its more fundamental vice and to seek the more sweeping relief to which he is entitled. Courts in treble damage suits are frequently misled by private parties whose incentives to make certain arguments or seek certain relief are not perfectly congruent with the public interest. A role is suggested for amici curiae (including public prosecutors) in such cases, as well as for enlightened judges.

<sup>181</sup> *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980).

<sup>182</sup> *Id.* at 481.

<sup>183</sup> See FTC, *supra* notes 21 and 91.

<sup>184</sup> The structural problems in the two cases differ, of course. Professional control of Blue Shield plans is challengeable as price-fixing if the Blue Shield joint venture is controlled by an organization likely to be judged too powerful by antitrust standards. See Havighurst & Hackbarth, *supra* note 57, at 381-82. Credentialing, on the other hand, draws procompetitive horizontal distinctions across the entire market and, not being viable on any lesser scale, cannot be attacked because of the horizontal market power possessed by its sponsors; such

simple boycott case because it appeared that the two Blue Shield defendants had in fact conspired to implement the restrictive policy toward psychologists.<sup>185</sup> In any event, the case illustrates the lack of wisdom of allowing plaintiffs to win private relief even though they have elected not to challenge directly the true vice of the arrangement. A proper appreciation of the "private attorney general" policy underlying private antitrust actions should suggest, in the instant situation, requiring plaintiffs to establish and remedy any structural violation as a precondition of receiving treble damages.<sup>186</sup> If there is in fact no structural violation of a kind that Part Two suggests may sometimes exist, then relief should be denied unless limited scrutiny reveals a defect in the procedures or standards employed or dishonesty in the opinions expressed. Courts should have no compunctions about adopting the rule of limited scrutiny and forcing plaintiffs to prove either a structural violation or an obvious failure to operate a competitor-sponsored credentialing scheme in a procompetitive way.

The problem examined here arises in pending litigation initiated by the State of Ohio against the JCAH.<sup>187</sup> Though brought by a public prosecutor, who should perhaps have more incentive than most private plaintiffs to seek a structural remedy, the case seeks only a revision of JCAH standards. By leaving the JCAH intact despite what appear to be fundamental defects in its current sponsorship, the case, if successful, would sanction the collective production of a single set of standards and relegate the courts to opining, as regulatory agencies, on what accreditation standard is best. Discussion in Part One concluded, however, that the accreditation standard in question in this litigation should not be condemned under a rule of limited scrutiny. Thus, Ohio should lose the case unless it amends its complaint to address what we regard as the real problem—not unfairness to psychologists, but the excessive influence that the JCAH enjoys by virtue of agreements among its sponsors not to compete in the business of accrediting hospitals.

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structural violations as might be identified consist of collaboration by bodies competing or potentially competing in the production of information.

<sup>185</sup> Indeed, plaintiffs, in successfully opposing defendant's certiorari petition in the Supreme Court, argued that the lower court's decision turned on a finding of such an illegal boycott. Under this reading, the court's emphasis on physician control may have served only to establish the boycott's anticompetitive impact on the boycotters' competitors. See Part One, n. 140 and accompanying text.

<sup>186</sup> Blue Shield plan subscribers were allowed to claim damages for the violations found in *Virginia Academy*. *Blue Shield of Va. v. McCready*, 102 S. Ct. 2540 (1982). Prospective relief was obviated by the existence of legislation prohibiting discrimination against psychologists. In addition, it seems likely that the defendants fearing similar results in other cases, would voluntarily break their ties with the medical profession.

<sup>187</sup> *Ohio ex rel Brown v. Joint Comm'n on Accred. of Hosps.*, No. C-2-79-1158 (S.D. Ohio, filed Dec. 14, 1979). See discussion in Part One, nn. 176-78 and accompanying text. This litigation is probably rendered moot by recent developments, see *supra* note 174, but the plaintiff could shift the ground of its attack.

## VIII. SUMMARY AND CONCLUSIONS

This Article has sought to clarify the legal principles applicable to private credentialing of health manpower and similar activities. In so doing, it has offered a rationale for the courts' apparent practice of allowing competitor-sponsored certifiers and accreditors wide latitude in publishing their opinions on the competence of their rivals or on the quality of their services or products. In our view, courts should confine themselves to looking for a rational means-ends connection between the standards and procedures employed and the procompetitive objective of informing consumers and other interested parties of relevant distinctions among offerings available in the marketplace. Certainly courts should intervene if a denial of certification or accreditation is aimed at suppressing competitive behavior and thus does more than simply disadvantage a competitor by conveying honest information and opinion about him to the public. But where the harm to competition takes only the latter form, courts should not require that the distinctions drawn by the credentialers or accreditors have anything more than a rational basis.

The argument that courts should resist the natural temptation to use antitrust or market-oriented common-law principles to root out unfairness by powerful credentialing or similar bodies depends heavily upon the observation that competitor-sponsored certification programs can facilitate informed choice and thereby improve the efficiency of the marketplace. Strict judicial scrutiny of credentialing decisions under a threat of antitrust treble damages and other liability could make credentialing programs so inclusive as to eliminate their informational value. Effective competition requires differentiation among the available options, and competitors should not be discouraged from trying to set themselves apart from their rivals. Even if the distinctions drawn by a particular credentialing scheme might be judged unfair under close scrutiny, the harms to the public interest done by such unfairness, like those associated with questionable advertising, may easily be offset by the incentives created for others to argue their case in the marketplace and to compete aggressively in other ways. In our view, a rule of limited scrutiny strikes the right balance between protecting consumers against the consequences of unfair competition and preserving a dynamic market featuring, among other things, a steady flow of claims and counterclaims. It will be noted that our position reflects the modern view that antitrust law should be predominantly concerned with consumer rather than competitor welfare. Thus, it leaves to the common-law courts the task of protecting competitors against unfair competition, a tort that should also, we judge, be narrowly defined so as not to reduce the flow of information useful to consumers or the vigor of competition in general.

Private credentialing is naturally confused with, but must be sharply distinguished from, public regulation. Because regulation is expressly intended to produce definitive and binding judgments about what goods or services may be bought and sold, it is appropriately administered by a single agency subject to close judicial oversight. Precisely because private credentialers lack the legal authority of regulators and perform a completely different function in the marketplace, the legal rules applicable to them must be different. Courts should therefore not accede to pressure from private litigants to approach influential credentialing bodies as if they were public agencies to be closely policed under the principles of constitutional due process and administrative law. If courts should elect to review the judgments of credentialers as they review the work of public agencies, they might simply confirm the credentialers in an unwarranted monopolistic status. Moreover, such close oversight amounts to an unwarranted assumption of a judicial power to resolve difficult technical and value questions that are better decided in the marketplace. Although it is tempting to look to private credentialing and similar "self-regulatory" bodies in professional fields for definitive judgments on behalf of society, there is no basis in law for according them that decision-making role. This Article has attempted to show that both legal analysis and sound policy require that such private agencies, though appropriately regarded as performing useful services in advising the public on important matters, should also be viewed skeptically as self-interested private bodies entitled to exercise only such trust and influence as they can earn in an unregulated, competitive environment.

Part One's conclusion that private parties complaining of unfair treatment at the hands of private credentialers should be relegated, in all cases except those of obvious anticompetitive abuse, to the remedies available to them in the marketplace should be more satisfying now that the arguments of Part Two have been advanced. The thesis of Part Two is that antitrust and other actions to curb private restraints on the flow of information can significantly reduce the power and influence of currently dominant credentialers and accreditors. By expanding the opportunities of those disadvantaged by adverse credentialing and accrediting decisions to get their message across in other ways, the antitrust enforcement agenda that we propose would go far toward obviating the need for close judicial scrutiny of private credentialing of health care personnel. Our conclusions also appear directly transferable to private standard-setting, certification, and accreditation programs in educational and industrial fields.

Whereas Part One concerned itself with the risk that public agencies—courts or regulators—would unduly restrain the flow of information, Part Two suggests that private actions, many of which have not heretofore been subjected to antitrust scrutiny, currently prevent the mar-

ket from generating as much consumer information as it is capable of offering. Partly because competitive markets, even under the best conditions, chronically underinform consumers concerning their options,<sup>188</sup> artificial restraints on the supply of information should be viewed with concern. It is extremely important to appreciate that the health care sector's widely noted problem of consumer ignorance is not entirely the result of market failure but has been exacerbated by collective actions limiting the flow and content of market information. This Article has gone well beyond the work of others in identifying the ways in which consumers of health care can be helpfully informed about the options available to them in the marketplace and the ways in which competition can be, and has been, harmed by private controls on the flow of information, opinion, and ideas.

Antitrust law has so far addressed private restraints on the flow of information in health care markets only in the form of restrictions on professional advertising. Such restraints were obvious targets for antitrust attack after the *Goldfarb* case because they took the form of naked agreements by individual providers not to compete in a particular way. On the other hand, competitor collaboration for the purpose of producing information and opinion in the form of credentials and accreditation has generally been seen only in its obvious procompetitive aspect. Thus, prior antitrust analyses of these forms of professional "self-regulation" under the rule of reason have focused only on the possibilities for policing the conduct of powerful credentialing or accrediting monopolies. This approach has reflected an assumption that there is no basis for challenging such collaboration even when it departs from its purpose of advising consumers of meaningful differences among providers, is organized on an excessive scale, or demonstrably eliminates valuable alternative sources of information and opinion on important technical issues and value questions. Our analysis has shifted the focus fundamentally by calling attention to the ways in which competitor-sponsored credentialing and accrediting can serve, like advertising restrictions, as an effective device for ultimately limiting the supply of information to consumers. By adopting this strategy, professional interests have prevented health care consumers from assuming larger decision-making roles and have thus kept power in professional hands.

This Article demonstrates how application of the Sherman Act's rule of reason, with its concern for ensuring that procompetitive goals be pursued without unnecessary harm to the competitive process, could use-

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<sup>188</sup> Though not the focus of this Article, public provision or subsidization of information can be an appropriate intervention in the marketplace, offsetting the market failure that results in an undersupply of information by the private sector. Among the mechanisms already in place for compiling and disseminating information about health care practitioners are the Congressional Office of Technology Assessment and various agencies and research programs within HHS. Mandating disclosure of certain facts by providers may also be an appropriate strategy for improving the performance of health care markets.

fully undermine at critical points the monolithic credentialing and accrediting systems that currently dominate the health care industry. Not only does it show how some credentialing and accrediting schemes suppress information, raise entry costs, and unduly standardize the production of personnel, but it also demonstrates the unlawfulness of certain hitherto unquestioned relationships among independent entities actually or potentially engaged in producing valuable consumer information. The key to the analysis—and the shortest and surest path to sensible legal results—is recognition that a market for commercially valuable information and opinion exists and can be kept competitive by applying traditional antitrust principles to those participating in it. Aside from the straightforward observation that consumer information is itself a product that should be produced under competitive conditions and whose output is subject to destructive trade restraints amenable to scrutiny under the Sherman Act, the analysis does not depart from the antitrust mainstream. It is hoped, however, that it clarifies that mainstream in places where it has been murky and that certain anticompetitive practices and institutions around which antitrust policy has heretofore flowed harmlessly will now be swept away.